







MEDICARE REIMBURSEMENT FOR RURAL HEALTH CARE CLINICS

HEARING

BEFORE THE

SUBCOMMITTEE ON RURAL DEVELOPMENT

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

MARCH 29, 1977

Printed for the use of the Committee on Agriculture, Nutrition, and Forestry





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MEDICARE REIMBURSEMENT FOR RURAL HEALTH CARE CLINICS

TUESDAY, MARCH 29, 1977

U.S. Senate,
Subcommittee on Rural Development of the
Committee on Agriculture, Nutrition, and Forestry,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 324, Russell Senate Office Building, Hon. Dick Clark (chairman of the subcommittee) presiding.

Present: Senators Clark, Leahy, Dole, and Bellmon.

STATEMENT OF HON. DICK CLARK, A U.S. SENATOR FROM IOWA*

Senator Clark. The subcommittee will come to order.

I would like to welcome all of you to the Senate subcommittee's hearing on rural health clinics. This Washington hearing follows two sets of hearings conducted in Vermont and Iowa last year by Senator Leahy and me. While those hearings were situated in two different parts of the country, they had a common thread—they revealed a persistent obstacle to health services in small towns and rural areas.

The obstacle I am referring to is a particular medicare policy that prohibits payment for care provided by nurse practitioners and physician assistants. Unless a physician is present, as you know, medicare will not reimburse. Nurse practitioners and physician assistants are a relatively new group of health professionals who have been specially trained to provide basic and emergency health care. Health clinics across America use their services because the areas have lost their physicians.

The 32 million rural medically underserved Americans therefore find themselves in a double-bind situation which must be corrected. Because of a lack of physicians they must rely on physician extender care; but that care cannot be reimbursed if no physician is

present.

Furthermore, the medicare policy clearly conflicts with other Federal health priorities. On the one hand, we are trying to curb the spiraling costs of health care. Yet, at the same time, we are forcing small town and farm residents to travel many miles to a large city in order to get reimbursable health services because that

^{*}See p. 100 for the prepared statement of Senator Clark.

is where the physicians and hospitals are located. While we spend millions of dollars to educate and train practitioners and physician assistants, we perpetuate a medicare policy that effectively curtails the utilization of those health professionals.

In preparation for this hearing this morning I requested assistance from the Department of Health, Education, and Welfare to

give us a better understanding of the nature of the problem.

The Social Security Administration provided us with data that underscores the extent to which medicare discriminates against rural Americans. I am submitting for the record a chart that shows the residents of urban States are receiving—on the average—two to three times the amount of medicare benefits than residents of rural States.

[The chart referred to above follows:]

AMOUNT OF PT. B MEDICARE BENEFITS PAID PER BENEFICIARY BY STATE, FISCAL 1976

State	Benefits	Percent of population rural, 1970
District of Columbia	\$439, 02	0
Hawaii	334, 53	16. 9
California	325, 45	9. 1
New York	293, 83	14. 4
Nevada	284, 35	19. 1
Arizona	251, 24	20, 4
Florida	250, 94	19. 5
Massachusetts	241, 67	15. 4
Rhode Island	236, 98	12. 9
Michigan	220, 28	26. 2
Colorado	215, 78	21. 5
Connecticut	214, 92	22.6
Oregon	211.34	32. 9
Maryland	210, 66	23, 4
Ohio	210, 40	24. 7
Montana	160, 49	46, 6
Alaska	156, 26	51. 6
North Carolina	154, 47	55. 0
Maine	154, 22	49. 2
New Hampshire	147. 98	43. 6
Indiana	146, 82	35. 1
Arkansas	146, 21	50. 0
South Carolina	143. 16	52. 4
Nebraska	142.59	38. 5
Illinois	137. 28	17. 0
Idaho	136. 91	45. 9
lowa	131. 91	42. 8
	130. 91	47. 7
KentuckySouth Dakota	124. 74	55. 4
	113. 05	39. 5
Wyoming	113.03	33.3

Sources: Bureau of the Census and Office of Research and Statistics, Social Security Administration.

Senator Clark. Information from the Bureau of Community Health Services tells us that the medicare policy serves to magnify an existing crisis situation in America's small towns. More than 30 million people live in rural areas which HEW has designated as medically underserved—30 million. This number represents one-third of the Nation's rural residents. The problem is even worse among those who benefit from the medicare program—the elderly. Forty percent of the rural elderly, amounting to 3.6 million older Americans, live in medically underserved areas—almost half.

Finally, the National Center for Health Services Research has compiled a body of valuable information about State policies and research findings on physician assistants and nurse practitioners; and within that report are contained the following major findings:

Forty-two States have legislation pertaining to physician assistants and 29 States have indicated an expanded role for nurse practitioners.

Twenty-six States—or half—allow medicaid reimbursement for physician assistant services and 18 States allow medicaid reimburse-

ment for nurse practitioner services.

This information illustrates the magnitude of the inequity in the medicare program. Today we are here to listen to those who have firsthand knowledge about this problem. We shall receive testimony from smalltown residents, clinic directors, nurse practitioners, physician assistants, rural physicians, and experts in the field of health care delivery, in addition to representatives from the Department of Health, Education, and Welfare and from various health professional organizations.

The subcommittee has also received written testimony on the subject from hundreds of citizens across the country, several Gov-

ernors, Representatives, and Senators.

At this time I request that all written testimony be inserted in the hearing record.

[S. 708 and a description of the bill follows:]

IN THE SENATE OF THE UNITED STATES

FEBRUARY 10 (legislative day, FEBRUARY 1), 1977

Mr. Clark and Mr. Leahy (for themselves, Mr. Abourezk, Mr. Bayh, Mr. Bumpers, Mr. Burdick, Mr. Church, Mr. DeConcini, Mr. Gravel, Mr. Hart, Mr. Haskell, Mr. Hathaway, Mr. Heinz, Mr. Huddleston, Mr. Humphrey, Mr. Inouye, Mr. Kennedy, Mr. McGovern, Mr. McIntyre, Mr. Mathias, Mr. Matsunaga, Mr. Metcalf, Mr. Pearson, Mr. Randolph, Mr. Riegle, Mr. Stafford, and Mr. Zorinsky) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to provide payment for rural health clinic services.

- 1 Be it enacted by the Senate and House of Representa-
- 2 tives of the United States of America in Congress assembled,
- 3 That (a) section 1833 of the Social Security Act is amend-
- 4 ed by adding at the end thereof the following new
- 5 subsection:
- 6 "(i) With respect to rural health clinic services, pay-
- 7 ment shall be made, on behalf of an individual, on the basis
- 8 of costs reasonably related to providing such services or on
- 9 the basis of such other tests of reasonableness as the Secre-

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tary may find appropriate. The provisions of subsection (b) shall not apply to this section.". 2 :3 (b) Section 1861 of such Act is amended by adding at the end thereof the following new subsection: 4 "(aa) (1) The term 'rural health clinic services' means 5 6 such services and supplies as would otherwise be covered (under subsection (s) (2) (A)) if furnished as an incident 7 to a physician's professional service, and such additional 8 services provided by a physician extender, furnished by 9 a rural health clinic to an individual as a primary care 10 11 patient. "(2) The term 'rural health clinic' means a facility 12 13 which "(A) is primarily engaged in providing rural health 14 15 elinia services; "(B) has an arrangement with one or more physi-16 17 cians under which provision is made for the regular 18 review by such physicians of all medical services furnished by physician extenders; 19 "(C) provides for the preparation by the super-20 vising physicians and physician extenders of medical 21 23 orders for care and treatment of clinic patients, and the 23 availability of such physicians for such referral and con-34 sultation for patients as is necessary, and for advice and

assistance in the management of medical emergencies;

35

1	(D) maintains chinical records on an patients;
2	"(E) has arrangements with one or more hospitals
3	for the referral or admission of patients requiring in-
4	patient services or such diagnostic or other specialized
5	services as are not available at the clinic;
6	"(F) has written policies to govern the manage-
7	ment of the clinic and all the services it provides;
8	"(G) has appropriate procedures or arrangements,
9	in compliance with applicable State and Federal law,
10	for storing, administering, and dispensing drugs and bio-
11	logicals; and
12	"(H) has appropriate procedures for utilization
13	review.
14	For purposes of this title, such term includes only a facility
15	which is not located in an urbanized area (as defined by the
16	Bureau of the Census) where the supply of medical services
17	is not sufficient to meet the needs of individuals residing
18	therein (including such rural areas as are designated by the
19	Secretary as areas having medically underserved populations
20	under section 1302 (7) of the Public Health Service Act,
21	and clinics that receive a majority of their patients from rural
22	medically underserved areas).
23	"(3) The term 'physician extender' means a physician
24	assistant, nurse practitioner, nurse clinician, or other trained
25	practitioner who is certified as a physician's assistant by the

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- 1 National Commission on Certification of Physician's As-
- 2 sistants or its successor, or who is certified as an adult-family
- 3 nurse practitioner by the American Nursing Association or
- 4 its successor, and who is legally authorized to provide any
- 5 physician services, as defined in section 1861 (q), in the
- 6 jurisdiction in which such services are provided.".
- 7 (c) Section 1862 (a) (3) of such Act is amended by
- 8 striking out "in such cases" and inserting in lieu thereof "in
- 9 the case of rural health clinics, as defined in section 1861
- 10 (aa) (2), and in other cases".
- 11 (d) (1) Section 1861 (s) of such Act is amended—
- 12 (A) by striking out "and" after the semicolon at
- the end of paragraph (8);
- 14 (B) by striking out the period at the end of para-
- graph (9) and inserting in lieu thereof "; and ";
- (C) by inserting after paragraph (9) the following
- 17 new paragraph:
- 18 "(10) rural health clinic services."; and
- (D) by redesignating paragraphs (10), (11),
- 20 (12), and (13) as paragraphs (11), (12), (13), and
- 21 (14), respectively.
- 22 (2) Section 1864 (a) of such Act is amended by strik-
- 23 ing out "paragraphs (10) and (11)" and inserting in lieu
- 24 thereof "paragraphs (11) and (12)".
- 25 (e) Section 1122 (b) (1) of the Social Security Act is

- 1 amended by inserting after the term "health care facility"
- 2 the following: "(including a rural health clinic as defined
- 3 in section 1861 (aa) (2) of this Act)".
- 4 (f) The amendments made by this Act shall apply to
- 5 services rendered on or after the first day of the third cal-
- 6 endar month which begins after the date of enactment of
- 7 this Act.
- (g) Nothing in the amendments made by this Act shall
- 9 be construed as superseding any State law regarding the use
- 10 of physician extenders and the provision of health services.

DESCRIPTION OF RURAL CLINIC BILL, S.708

What is the current Medicare policy toward the reimbursement of rural

health clinic services?

Reimbursement is only allowed for physician services or services provided by physician extenders under the direct supervision of physicians. "Direct" has been interpreted to mean that the physician must be physically present during the provision of extender services.

In what manner would rural health clinics be reimbursed under the Clark-

Leahy bill?

Reimbursement would be related to the actual, reasonable costs incurred by the clinic in the provision of primary health care services.

What requirements would a clinic be required to meet in order to qualify

for reimbursement?

It must have: *Periodic review by physicians of services provided by physician extenders; *standing orders, physician referral and consultation; *clinical records; *referral and admission arrangements with a hospital; *procedures for drugs; and *utilization review procedures.

Where must a clinic be located to be eligible for reimbursement?

The clinic must serve a rural population where the supply of medical services is insufficient to meet its needs.

Senator Clark. Most of the testimony today will be focused upon S. 708, a bill which Senator Leahy and I introduced this session to allow medicare reimbursement for rural health clinic services. S. 708 now has 45 cosponsors, so it has substantial support from Members of the Senate.

The key elements of the bill are as follows:

One: The clinic itself, rather than any particular provider within the clinic, would be reimbursed for primary health care services.

Two: The reimbursement would be based upon the costs-rather

than charges—of providing those services.

Three: While S. 708 does not require the continual presence of a physician at the clinic, it does allow reimbursement to clinics where physicians and the other primary health practitioners are simultaneously providing care.

Four: The clinic must serve a rural, medically underserved popu-

I want to thank the staff of the Appalachian Regional Commission for their work, incidentally, on this legislation. Their direct interest stems from the fact that several of the Appalachian Regional Commission supported clinics may soon have to close down as their grant periods end, unless this medicare policy is modified.

Now, the subcommittee is especially interested in learning how S. 708 should be improved. Therefore I am requesting that witnesses be specific about the strengths and the weaknesses of the bill, and about their recommended changes. Furthermore, in order to hear from a large group of witnesses, and to allow the subcommittee to question them, I ask that all the prepared remarks be limited to 5 minutes. As is often the case, we have taken on a very large subject with many, many witnesses—I think it looks like 30 or 40. So, we want to cover everyone whom we have invited to testify.

Again, I thank those of you who will testify today and are in attendance, and who have written to us, for contributing to this hearing; and we look forward to an informative and productive hearing. As I have said earlier, Senator Patrick Leahy of Vermont has been a leader in this area. He held the first hearings in the

country, in fact, regarding this problem. He serves, of course, on this subcommittee, and in fact we are going to share the Chair here today.

So, I think at this time I should ask him for any opening remarks

that he might have.

STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM VERMONT*

Senator Leahy. Thank you very much, Mr. Chairman.

A little over 1 year ago this subcommittee did hold hearings in my home State of Vermont under the auspices of the Chairman. At these hearings we looked at some of the ways small rural communities were attempting to cope with the most serious health care problem facing rural America—that is the shortage of primary health care personnel.

We discovered that many of those areas which lack physician's services have come to rely on local clinics for their primary health care needs. These clinics are staffed by specially trained health professionals called nurse practitioners who are able to diagnose and treat primary and emergency needs. Physicians in nearby communi-

ties provide both backup and audit services.

The organization of the clinics is as diverse as the communities they serve. But, one factor is central to all successful efforts: Community support and commitment to the clinic. At the hearings in Grand Isle, Vt., there were about 100 users of the health clinic present who attested to this community support. I might add, Mr. Chairman, they testified at a hearing of this commission held late one evening on an evening where I believe the temperature eventually dropped to about 20 below zero, but they all showed up to testify.

I would like to include in today's hearing record the testimony given in Grand Isle, which clearly demonstrates the community

support of the health clinic.

Senator CLARK. All right, it will be included.**

Senator Leahy. I think there is a lesson to be learned. I have serious doubts whether we in Washington can design or impose any health care system in any community in this Nation if that com-

mitment and support does not exist at the local level.

However, we must do everything within our power to remove any barriers which hinder the viability of these much needed clinics. I am very pleased, therefore, to join you in sponsoring S. 708, which would break down a barrier created by current medicare policy. At present, medicare will reimburse for services performed by nonphysician health personnel only if these services are performed in the presence of a doctor.

This regulation puts rural clinics in a Catch-22 situation. For example, in Grand Isle, Vt., nurse practitioners are used because there are no doctors, but there must be a doctor present if the nurse practitioner is to be reimbursed. Clearly, this discrimination compounds the already massive health care problems of rural America,

^{*}See p. 101 for the prepared statement of Senator Leahy. **See p. 102 for the material referred to by Senator Leahy.

problems that are the same whether they are in Vermont, whether they are in Iowa, whether they are in Arkansas, or whether they

are in virtually any one of the 50 States.

I am hopeful that the passage of this measure will help alleviate one of the problems faced by these clinics. Long-term financing. Currently, funds may come from many sources, most of which are short term or undependable. By providing reimbursement of these clinics on a cost-incurred basis, we will literally be throwing a lifeline to thousands of people in rural America.

I know, Mr. Chairman, I look forward to hearing the witnesses we have before us today. I know that a number of them have taken extraordinary steps in trying to aid what your bill attempts to get through, and I think that their testimony is probably going to emphasize why so many of our colleagues on both sides of the aisle

joined in this effort.

Senator Clark. Thank you very much. I mentioned a little earlier that we now have 45 cosponsors and several others that are con-

sidering sponsorship.

We are particularly happy that Senator Dale Bumpers of Arkansas, although not a member of this committee, takes a special interest in this legislation and the whole problem of health care. So, we appreciate his assistance and welcome him particularly this morning to be the opening witness.

STATEMENT OF HON. DALE BUMPERS, A U.S. SENATOR FROM ARKANSAS*

Senator Bumpers. Thank you, Mr. Chairman. First I want to thank you and the distinguished Senator from Vermont for allowing me to speak in support of S. 708, a bill which would provide medicare reimbursement to cover the reasonable cost incurred by

primary health care clinics.

Arkansas, which is my home State, has an extreme health manpower shortage at the present time. According to an American Medical Association survey, as of December 31, 1974, Arkansas ranked 48th among the 50 States in physician population ratio. That is, Arkansas has 83 physicians for 100,000 people providing patient care. The national average for physician population is 132 physicians for 100,000 people. It would take an additional 1,000 doctors for Arkansas to equal the national average.

The Public Health Service has declared 29 counties in Arkansas as critical health manpower shortage areas. We are facing an extreme distribution problem, also. At the present time there are 1,635 patient care physicians working in the State. Approximately one-half of these physicians are located in Sebastian and Pulaski Counties, two counties which make up 20 percent of the State's population

This health manpower shortage is critical in Arkansas. When I was Governor of Arkansas, I appointed a primary health care committee and instructed the committee to design a program to meet the primary health care needs of the State.

^{*}See p. 116 for the prepared statement of Senator Bumpers.

All of the recommendations of that committee have been enacted. The State created six area health education centers and three fully accredited residency programs in family practice in different areas of the State. A scholarship program for medical students who would agree to practice in rural areas of the State has also been created. And I might add, that has been very effective, much more so than I had anticipated.

One of the major components of that program was the development of a physician assistant training program to meet the rural health care needs of the State. Funds were appropriated to start the physician assistant training program. However, the State Medical Practice Act did not provide authority for physician assistants

to function adequately in the State.

This problem was solved by the Arkansas General Assembly which provided for the certification of physician-trained assistant by the State Medical Board. The passage of this act will allow the State to recruit physician assistants from throughout the country.

At the present time there are several clinical nurse practitioner training programs in operation at the University of Arkansas' School for Medical Sciences. A 5-year baccalaureate program graduates 40 to 50 students a year. A clinical nurse practitioner post-graduate program has approximately 20 graduates per year, and a graduate clinical nurse practitioner program graduates approximately 20 graduates students with masters degrees each year. However, these graduates have difficulty fitting into the existing health

care delivery system.

It is my understanding that title 18 of the Social Security Act does not expressly recognize health care clinics or physician extenders as providers. Physicians practicing in primary care clinics are reimbursed by medicare for their own services and for charges for services "incident to physicians' services," such as laboratory and X-ray services. But, it does not reimburse for nursing services outside of a physician's office unless they are performed under the direct supervision of a physician. For example, if a nurse accompanies a physician on house calls and administers the injection, the services are covered; if the same nurse makes the call alone and administers the injection, the services are not covered since the physician is not personally supervising the injection.

This distinction in our medicare laws is absurd. The result is inequitable for patients in rural areas, especially. The effect of this policy has been to completely exclude from reimbursement the satellite clinics, which are absolutely necessary and increasingly prevalent in rural areas. In these health clinics, a physician extender provides services to an isolated population under the general, but not immediate, supervision of a physician. As a result of the coverage exclusion, medicare beneficiaries in such areas are denied the benefit of the clinics. In summary, the service is available in certain rural

areas, but it is not reimbursable.

This treatment by medicare is inconsistent with the actions of a variety of Federal health programs, which have been instrumental in promoting the physician extender concept, both in the form of training and in grants to underwrite initial operation of such clinics.

In light of the extreme medical manpower shortage which we have in my State, I am extremely interested in the development of the rural health care centers. There are data available demonstrating that the use of medical practitioners can expand the basic load of medical practices. A study of physician extenders, including nurse practitioners, commissioned by HEW concluded that, "Given the assumed task delegations and the expected level of acceptance, the median estimate of the need of physicians in the target years could be lowered by as much as 22 percent."

In a study reported in the New England Journal of Medicine in January 1974, the addition of two nurse practitioners enabled two family practitioners to increase the number of families under their

care by 22 percent in the course of 1 year.

The evidence that is available on the quality of care rendered by nurse practitioners has been favorable. A key ingredient of the quality control in all reported demonstrations has been the active involvement of physicians, who audit the work of the nurses, establish protocols for their practices, and visit the sites periodically to see the patients and consult with the nurses.

Controlled studies have generally shown the patients to be as satisfied with the care provided by nurse practitioners as they were

with care for similar problems provided by doctors.

Recognizing the extreme importance of clinical nurse practitioners and nurse clinicians in the delivery of primary health care, Mr. Chairman, I recommend one amendment to S. 708, "Clinical nurse practitioners" and "nurse clinicians" should be distinguished from "physician extenders" in the bill. Clinical nurse practitioners and nurse clinicians provide services beyond and in addition to the services offered by a physician. For example, they often provide continuing care or overall supervision to patients with long-term illnesses. They represent a separate type of service which is generally needed in rural health clinics and should be distinguished from the services of a physician assistant.

A number of innovative approaches to primary health care delivery are being tried throughout the country, and especially in the rural South. However, much more remains to be done. Many of the projects currently underway are going to die without some fundamental changes in governmental financing programs. Most approaches are being tried on a small scale, and that falls far short

of meeting the total need.

Mr. Chairman, I congratulate you and Senator Leahy for introducing this legislation. Passage of this bill would provide access to medicare benefits for thousands of eligible beneficiaries who now reside in areas designated as medically underserved. It also would provide a financial benefit to the medicare trust fund. If the pattern of early primary health care clinics continues, part A savings on hospitalizations should be substantial. Recent studies showed reductions of 52.7 percent in Memphis clinics, 70 percent in Hyden, Ky.'s Frontier Nursing Service, and 35 percent in the neighborhood health centers.

Mr. Chairman, again I thank you, and I will be happy to answer any questions you might have on any of these programs in my State,

which my experience is limited to.

Senator Clark. Well, it is an excellent statement. It is very clear

and to the point, and it is well documented.

I can say you are particularly interested in the problems of health care in Arkansas. You say on the first page that the physician-patient ratio is 48 to 50; and I notice you say that of the 1,600 physicians, half are in two counties. That is just about exactly what we have in Iowa as well, half of the physicians in two counties. And yet, you have done a great deal in Arkansas—at least you are in the process of doing a great deal to try to alleviate the doctor shortage.

Senator Bumpers. We doubled the size of the medical school and tried to double the number of doctors when I was Governor. But first of all, we are not going to feel that for some time. Second: I have the very distinct feeling that the distribution problem is going

to be with us always.

Senator Clark. How long did it take you to double the size of the medical school?

Senator Bumpers. It is yet under construction. Senator Clark. I see, you just got the funds.

Senator Bumpers. We got the money appropriated. The construction started while I was still there, but it has not been completed. And I might add that even after it is completed next year, in 1978, it will still be 5 years until we begin to feel the effect of it; in most instances it will be 8 or 9 years.

Senator Clark. Thank you very much. Senator Leahy?

Senator Leahy. I was extremely impressed with the statement.

Senator Bumpers. I am a very impressive guy, Patrick.

[Laughter.]

Senator Leahy. I remember receiving a memo from you to that effect the first day I was here.

[Laughter.]

Senator Leahy. I know the work you did as Governor, and I think having both that perspective and then the perspective here, it is even more worthwhile to the committee. It brings out what Senator Clark and I already noted, that these problems are not just in Iowa and Vermont, but in Arkansas and in any other rural area.

I think that was probably one of the most telling points made in response to the chairman's statement, that even if you doubled the medical schools, distribution is still going to be a problem as long as we are faced with traditional ways of doing things, solely traditional care. Distribution will not only be a problem, it will be an impossibility, it will continue to exist, no way is that going to change.

So, I appreciate your statement and your support; and I will

look closely at your suggestions on the amendment.

Senator Bumpers. Mr. Chairman, if I might just add one further self-serving statement—

[Laughter.]

Senator Bumpers. The last 2 years I was Governor, my wife undertook a mass immunization program in our State to immunize all the children against childhood diseases. As a result of that program Arkansas went from 48th among the 50 States in childhood immunization levels to No. 2; Alaska still has a higher immunization

level for children than Arkansas. She is now trying to do the same thing on a nationwide basis. It could very easily be done if it were not for so many bureaucrats standing in the way. Arkansas has not had a case of measles since 1974 as a result of that. I do not believe we had more than three cases of rubella. And you know, these diseases are more devastating than most people ever think about.

I mention this example to make this point. It was the Arkansas League of Nurses that assisted her in taking the lead. The Arkansas Medical Society and the department of health joined in. All the various public and private organizations coordinated their efforts to make that program so successful in our State. There is not anything that can do more for health in States like mine than prevention. It will not just help poor States. I might point out that Los Angeles had a big measles outbreak about 60 days ago. They only had 2,000 doses of measles vaccine; they had to bring extra vaccine from 50 miles away. They found that the national stockpile of measles vaccine was so low, it was almost criminal neglect.

The more physician extenders you have, the more nurse clinicians you have, the more of any kind of allied health care personnel you have, the more effective these immunization and preventive health care programs would be. I think that a massive nationwide program would probably cut \$5 to \$10 million off the cost of health care in

the country.

Senator Clark. What did you immunize against?

Senator Bumpers. Mumps, measles, rubella, DPT, and polio. Senator Clark. I see. Well, thank you very much, and we will be happy to consider the amendments you have suggested to us.

Senator Bumpers. Thank you very much.

Senator Clark. Senator Bentsen had also hoped to be here, but he is involved in a markup of the clean air bill. But, he is a cosponsor of this legislation and is a member of the Senate Finance Committee, the subcommittee, of course, which is going to consider this legislation.

So, I would like to put his statement in the record.*

Next we are going to hear from Dick Warden. Dick, if you want to sit up here? You are going to be accompanied, I understand, by Karen Davis, Deputy Assistant Secretary for Planning and Evaluation; as well as Clifton Gaus, Director, Division of Health Insurance Studies, Office of Research and Statistics, Social Security Administration; Dr. Michael Samuels, Associate Bureau Director for Health Underserved Areas, Health Services Administration, and Susan Horowitz, Division of Medicine, Bureau of Health Manpower of the Health Resources Administration.

Is that an accurate description, Dick? Mr. WARDEN. It is, Mr. Chairman.

Senator Clark. We are particularly honored to have you, Assistant Secretary for Legislation. I believe your actual nomination has been cleared, and I believe we are going to be voting on that today. So, we are very pleased to have you here.

I know that Mr. Warden also represents a department whose Secretary, Mr. Califano, has a personal interest in this subject, as

^{*}See p. 118 for the statement of Senator Bentsen.

demonstrated in his discussion of it in his report to President Carter entitled "American Families: Trends, Pressures: and Recommendations."

So, Mr. Warden, you proceed in any way you think appropriate.

STATEMENT OF RICHARD D. WARDEN, ASSISTANT SECRETARY FOR LEGISLATION-DESIGNATE, ACCOMPANIED BY DR. KAREN DAVIS, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION; DR. CLIFTON R. GAUS, DIRECTOR, DIVISION OF HEALTH INSURANCE STUDIES, OFFICE OF RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION; DR. MICHAEL SAMUELS, ASSOCIATE BUREAU DIRECTOR FOR HEALTH UNDERSERVED AREAS, HEALTH SERVICES ADMINISTRATION, AND SUSAN M. HOROWITZ, DIVISION OF MEDICINE, BUREAU OF HEALTH MANPOWER, HEALTH RESOURCES ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Warden. Thank you very much, Mr. Chairman, I appreciate very much the opportunity to be here this morning to represent the Department, even though I still have the word "designate" following that title.*

Senator Clark. You are speaking for the Department, though. Mr. Warden. I am speaking for the Department. At the time we indicated I would be here to testify, we assumed that this nomina-

tion would be cleared.

You have already introduced my colleagues who accompany me here this morning, so I will not go through that. They and I will be available for any questions members of the subcommittee may have.

It is a great pleasure to be here today to share with you the Department's view on the subject of reimbursement on a cost-related basis for services provided by physician extenders in rural clinics

in medically underserved areas.

It is our hope that the Congress will take action to help alleviate the very serious problems in medically underserved areas. We hope later to have the opportunity to testify on this vitally important subject before the Finance Committee, the committee with jurisdiction over the Social Security Act, which your bill, S. 708, sponsored by yourself and Senator Leahy, and 45 other Senators, would amend. We appreciate the opportunity to share our views with this subcommittee as well.

Assuring access to care for residents in rural and other underserved areas is a difficult problem. These areas are often sparsely populated and poor. Currently about 1,500 of the 3,000 counties in the United States and numerous subcounty areas are officially classified as medically underserved. Over 20 percent of the population lives in these areas.

It has been estimated that since 1969, \$65 million in Federal funds have been expended to educate and promote the utilization of physician assistants and nurse practitioners in the health care delivery

system.

^{*}See p. 121 for the statement of Mr. Warden.

Providing technical and financial support for the training of physician extenders and development of service delivery sites and incentives for health professionals to locate in such areas are not enough. Unless these facilities and professionals can be reimbursed from public and private insurance programs, they cannot be economically viable in the long run.

In this regard, provisions of the medicare law have made it difficult for clinics to be reimbursed under medicare. Clinics have often been unable to obtain medicare reimbursement for services provided by physician extenders simply because a physician was not on

site at all times as required by medicare.

Mr. Chairman, in your letter inviting us to testify, you indicated you wanted to receive testimony specifically on S. 708, which you, Senator Leahy and others cosponsor. We support the objectives of S. 708 and commend your efforts in this area. But we would suggest four changes which we believe would strengthen the bill.

One: Allow clinics in all underserved areas to participate.

Two: Reimburse clinics for all physician services on a cost-related basis.

Three: Retain the medicare deductible provision for beneficiaries

receiving care in clinics; and

Four: Allow the Secretary to establish appropriate education and training standards for physician extenders recognized under this

reimbursement program.

We believe clinics employing nurse practitioners and physician assistants under general physician supervision, in urban and rural underserved areas, should be eligible for medicare cost reimbursement. Unfortunately, large numbers of Americans living in cities do not have access to a source of primary care. The Department estimates that of the 45 million people living in medically underserved areas, more than 14 million are urban residents. Given recent experiences with the so-called medicaid mills in urban areas, we understand concern about extending coverage to clinics in these settings.

The Department also proposes to reimburse clinics for the supervisory services of physicians and for direct physician services on a cost-related basis. We believe this approach is preferable to various combinations of cost-related reimbursement for physician services. Cost-related reimbursement would be far more effective from the standpoint of cost control and fraud and abuse control than a fee-for-service method. Additionally, this approach is administratively less complex because it avoids the problem of differentiating between supervision and direct physician services, a problem which has been difficult to solve in the teaching hospital setting.

We do not believe that the Department's approach represents a radical departure from the existing physician reimbursement practices. The Department's proposal in no way limits physicians from billing the program on a fee-for-service basis as they currently do. Our proposal merely gives practices utilizing physicians and physician extenders the option of being classified as a "clinic" and then

being reimbursed as a clinic on a cost-related basis.

We recommend replacing the provision prescribing certification standards for physician extenders with one which would allow the Secretary to develop appropriate qualification standards for physician extenders recognized under this program. We believe that leaving this technical issue to secretarial discretion would give the bill needed flexibility and the capacity to respond to changing standards in training certification of physician extenders.

Mr. Chairman, we view legislation in this area as an important and necessary start in promoting access to care for all Americans,

regardless of where they live.

I have summarized this statement to keep within your 5-minute limitation, Mr. Chairman, but I would appreciate it if the statement could be included in the record.

Senator Clark. It will be included.

Mr. Warden. My colleagues and I would be pleased to answer any questions you or other members of the subcommittee may have.

Senator Clark. Let me start with two questions. It is a good statement, and we really appreciate the support of the administration on this legislation. You made 3 or 4 specific further recommendations on page 3, the bottom of page 3, and the top of page 4. I am not sure that we have any disagreement on point B. As I understand it, you propose that the bill reimburse clinics for all physician services on a cost-related basis. At least that is the intention of our legislation. It may be that we can look at it more carefully. I think we are in agreement there. I do want to ask about some of the other areas.

Now, if this legislation were expanded to urban areas, how do you propose that we should control what might be an unnecessary proliferation of clinics? That is one of our concerns, given some of the fraudulent practices that we have seen of this general nature.

Do you see that as a problem, or not?

Mr. Warden. At the present time, Mr. Chairman, as I understand it, there is a problem in a number of urban areas, as well as in many rural areas. We feel, that in light of the fact that decent and acceptable health care is not available to many Americans living in cities, that the bill really ought to apply in the same way in rural and urban areas.

We recognize that to deal fully with the problem is going to cost considerable amounts of money, to cover the needs of the entire Nation. We appreciate the fact that your bill would start with the rural areas, but we think it is important that we examine very carefully what the situation is in some of our urban areas—and particularly in central cities and also to deal with the problem that exists there.

It was that fact which has led us to make the proposal that perhaps the bill should be broadened. We will be testifying for this objective when we appear before the Finance Committee, and before the House Ways and Means Committee's subcommittee.

Senator Clark. I think it is difficult to argue about the need for medical assistance in central cities because obviously there are underserved areas there, just as there are underserved areas in the rural part of the country.

I am curious as to how that might break down statistically. I do not know whether you have the facts or not; but does the administration believe that the problem of access to primary health services is greater in the rural areas than in towns, urban areas, or central cities, in terms of your designation? Are there some statistics available on that?

Mr. WARDEN. We do have statistics available, and we can probably provide more to augment what we have with us here this

morning

Just take the situation in Iowa, for example, 66,700 people live in urbanized, medically underserved areas. This represents 20 percent of all Iowa residents who live in medically underserved areas. Obviously the problem is more serious in terms of numbers of people involved in rural underserved areas in Iowa. But, nonetheless, 20 percent of the people who live in those kinds of areas without adequate service live in urban situations.

Senator Clark. How would that look nationally?

Mr. Warden. The total population living in medically underserved areas in 1970 was 45.7 million; that represented 22 percent of the total population in the country.

Senator Clark. These are urban areas?

Mr. Warden. No: these are medically underserved areas nationally. These are 1970 figures, 45.7 million, 22 percent of the total U.S. population was living in medically underserved areas. Of the 45.7 million, 14.1 million, or 6.8 percent of the total U.S. population, is in urbanized, medically underserved areas.

Senator Clark. That is a little less than one-third, right—15 to

47?

Mr. Warden Yes; approximately.

Senator Clark. And the other two-thirds would be in rural areas?

Mr. WARDEN. That is correct.

Senator Clark. Now, what do you use as urban, 2,500?

Ms. Davis. Mr. Chairman, the definition of "urbanized" is a city of 50,000.

Senator Clark. Well, I just want to stay with this one area before going to Senator Leahy—I am sure he has some questions—and I have some others. I think we have someone from the Social Security Administration here. Do they feel they are prepared to handle the administration costs and burdens of urban clinics?

Mr. Warden. The reference to this activity in the budget presupposes the application of the program to both urban and rural

areas.

Senator Clark. That is the cost of \$25 million?

Mr. WARDEN. The \$25 million obviously does not deal with the total problem.

Senator Clark. What you recommended would include the urban clinics, obviously.

Mr. WARDEN. Yes.

Senator Clark. So, the simple answer is that the Social Security Administration is prepared to handle the administrative cost for the urban areas.

Mr. WARDEN. I would like to defer to Dr. Gaus.

Dr. Gaus. We do not believe it will be a problem. We are, in fact, gearing up now within the Division to expand the scope of defer-

ment substantially; and this would phase right into the new legislation, if it is enacted. I do not believe there would be a problem.

Senator Clark. Now, our estimates of what this would cost the first year in the rural areas were, I believe, \$20 million. Your estimate for the first year in rural and urban areas would be \$25 million. Do you know how we might differ in that area, are we talking about \$20 million in rural areas and \$5 million in urban areas, or are you talking about some other kind of split?

Mr. Warden. Yes, that is what we had in mind—\$20 million for rural areas and \$5 million for urban areas, at the outset. Those fig-

ures will be rising in later years.

Senator Clark. We assume under S. 708 that initially 500 clinics would be covered, and by 1982 there would be 950, that is almost twice as many.

Under the administration bill, we assume 725 clinics would be covered initially, and 1,945 and 1982. That gives you some indica-

tion.

Senator Leahy?

Senator Leahy. I would first like to say, it is certainly nice to see you here; you are certainly no stranger to hearing rooms on the Hill.

Let me follow up on what the chairman was asking. I am always concerned about our rural areas—not that we are not concerned for our cities.

But I look at so many programs, housing programs, health programs, poverty programs, or anything else. We can just cite example after example where, on the basis of need, with no matter what kind of formula was set up initially, the urban areas are getting substantially more on a per capita basis. The urban areas do almost twice as well in most programs, compared to the rural areas. Why? Perhaps because of the concentration of people there; or

Why? Perhaps because of the concentration of people there; or perhaps because of the bigger political clout they have in having a group of voters all in one unit, I do not know. Or maybe it is just that most of the Government sits here in Washington, and so often it is a constituence of people within the same Government, and they do not have time to go out and find that there are places other than those where there are nonstop flights, to Washington, New York, Chicago, Detroit, whatever.

I would hope that if we expand this program that we really set

I would hope that if we expand this program that we really set up some very good program for the problems in rural areas where a person might have to travel 100 miles to a decent health facility. Those programs are very different from the ones in an urban area, where it might be nice to have a neighborhood clinic instead of traveling 3 or 4 miles to a hospital facility. That does not create

anywhere near the problem that the rural areas face.

While I see the breakdown now \$20 million for rural areas, and \$5 million for urban areas, I would be very interested in seeing the

projected breakdown what kind of ratio occurs.

I would also be very interested in a guarantee that funds are not going to be syphoned off and the program become very much an urban-oriented one, where we already have substantial health care programs, as opposed to a rural one. That is not so much in the way of a question, but a statement on philosophy. And I would hope that the Department, in making that proposal, would be guided

very strongly in that way. This is designed, at least by the sponsors—and Senator Clark and I are the main sponsors of this—we envision it as a rural program, aiming for a problem that is to a

large extent peculiar to the rural areas.

Incidentally, there are several clinics whose eligibility for grant funds expires between April and December, other than just started, who need deficit support. Did HEW support a budget request to increase appropriations for the rural health initiative program so these clinics can survive until S. 708 is enacted? Would you like to

answer that for the record?

Mr. Warden. If I can recast your question in the context of current activities, we have been moving along two parallel tracks in the rural health area. Our first has been to push for legislative reform in the medicare program to provide reimbursement to physician extenders. Second, we have attempted to make sure that current programs continue to provide needed services, placing emphasis upon improved access and delivery. In this regard, under the community health centers, migrant health, and medicaid programs, we have earmarked \$44.7 million—an increase of \$5 million over 1977 and \$22 million over 1976—for rural primary health care projects. Thus, our budget request is supportive of the general measures contained in S. 708.

Senator Leahy. I realize that is one question I should have gotten

to you ahead of time. But we are interested in that.

Senator Clark. Would you be willing to consider that, Mr. Warden?

Mr. Warden. I certainly will convey your hope to the budget people in HEW. I am not sure that question was considered. We did not have a long period of time in which to consider the budget amendments. I am not sure that is an issue which was discussed.

Senator Leahy. Would you also convey my concern—and this is not an anticity concern by any means—but by virtue of the various subcommittees I serve on, the Appropriations Committee, HEW seems to be exclusively dealing with urban problems. But this program is trying to improve a situation in the rural areas. If that should disappear, we are going to be back to the same problem we were before.

Mr. Warden. I understand your concern. Senator Leahy. Thank you, Mr. Chairman.

Senator Clark. Well, as I look at the four proposals that you make, they are different to some degree from this legislation—I think three of them are not too far apart from it.

Mr. Warden That is correct.

Senator Clark. On the second one, I think we are in complete agreement, the question of retaining the medicare—on the bottom of page 3—retain the medicare deductible provision for beneficiaries receiving care in clinics. It is our feeling that the deductible provision is a deterrent to care, but I suppose it is no more so than the deductible provisions in other areas of medical care. You also propose to allow the Secretary to establish appropriate education and training standards for physician extenders recognized under this reimbursement program. Our concern there would be that they be national standards, not just State standards. I expect we are not in disagreement, but I had better ask.

Mr. WARDEN. I do not think so. We believe they should be national standards too. That would not preclude the States from going

beyond what is required in the national standards.

Senator Leahy. If I could just interject on that, I think that is important, and I think it is something where a great deal of work can be done with the States in setting that up, but also with private health insurance plans. I know that Blue Shield in Vermont has—on an experimental basis in a couple of areas in Vermont reimbursed nurse practitioners. I think to get the insurance companies actively involved in this, they are going to need some help insofar as standards, what they will, and will not reimburse for.

Senator CLARK. We thank you very much for coming up, we appreciate it and are looking forward to working with you in trying

to pass this legislation and get it implemented as well. Mr. WARDEN. Thank you very much, Mr. Chairman.

Senator Clark. We will just have a brief film here now which was shown on CBS morning news on March 1, 1977. It illustrates the problem caused by the lack of reimbursement to clinics for the health care practitioners in rural clinics. This system discriminates against poor medicare patients and threatens to end health services for rural residents if clinics close. You see contrasting clinics in Washington, D.C., and Atkinson, N.C.

The film presents the problem of rural clinics regarding reimbursement, as well as the comments of Congressman Dan Rostenkowski, who is the sponsor of a bill that provides reimbursement

through medicare in the House.

So, David, if you know how to operate the video tape, go ahead. It is just a very brief film.

[Whereupon a short film was presented.]

Senator Clark. Thank you.

We are going to hear next from Dr. Vernon Wilson. Please come up to the table. I would like to say that Dr. Wilson is vice chancellor for medical affairs at Vanderbilt University in Nashville, Tenn. He is acting director of a newly created primary care center at Vanderbilt. He has a career as a medical educator, has been active for the past 25 years in family practice, and served as Administrator of the HEW Health Services and Mental Health Administration.

We are very pleased to have you here, and you may proceed in any way you desire.

STATEMENT OF VERNON WILSON, M.D., VICE CHANCELLOR FOR MEDICAL AFFAIRS, MEDICAL CENTER, VANDERBILT UNIVERSITY, NASHVILLE, TENN.

Dr. Wilson. Thank you, Senator Clark. You have in hand more complete, written testimony. I am going to restrict myself, in respect for your time, to brief comments; and will be happy to answer any questions.

Senator Clark. Your entire statement will be inserted in the

record as presented.*

^{*}See p. 123 for the prepared statement of Dr. Wilson.

Dr. Wilson. As you have already indicated, most of my professional career has been devoted, as a matter of fact, to various endeavors related to rural health. I was born and raised in north-western Iowa—

Senator Clark. Northwestern Iowa?

Dr. Wilson. That is right. Senator Clark. Where? Dr. Wilson. Kingsley, Iowa. Senator Clark. Really?

Dr. Wilson. Hardly anybody knows where that is.

Senator Clark. We held hearings in Kingsley, as a matter of fact. Dr. Wilson. That is a part of the world where a lot of good people are from. I have not been back to check who has left there. Senator Clark. They tell me all the people from Iowa are.

Dr. Wilson. I am of that opinion myself. In any event, each of the State universities in which I have worked have also been active—this being in Kansas and Missouri—and to some degree successful in their attacks upon the problems of rural health care. Vanderbilt University presently, through its student health coalition, has conducted a number of programs in the area of rural health throughout Tennessee and central and southern Appalachia. There are presently 12 such clinics operative in the eastern Tennessee area, which serve the residents in those areas, in physician-shortage areas.

Vanderbilt itself has been involved in establishing programs for nurse practitioners and physician extenders. From that background of interest I would like to very much endorse the need for medicare reimbursement in the health clinics in Tennessee and throughout rural America. These isolated clinics—and you have had testimony already on this fact, with which I am familiar, must rely on staffing by nurse practitioners and physician assistants, with supervisory physicians present on a regular basis, but on call most of the time.

As just pointed out in the film, medicare reimbursements can only be provided for costs incurred while a physician is present, and patient visits from senior citizens must occur only on such days as the physician himself is present, if they are to be reimbursed. This places a severe financial burden and a logistical strain on the clinics'

elderly clients.

In Tennessee the comparable problem of medicare reimbursement has been alleviated by legislation which permits medicaid reimbursement for costs that were incurred by patients in clinics operated under general physician supervision. At the present time there are 70 such clinics in the State of Tennessee, with care provided by a nurse practitioner under formal protocol.

Senator CLARK. These are rural clinics?

Dr. Wilson. Yes, the ones supported by the State. The care that is provided there, the State administrators believe, has reduced hospitalization and markedly increased the quality of care for individuals in these rural areas. Based on these programs we can attest—and I talked with the commissioner before I came in—that by exercising proper supervision and diligence in the selection of the activities that are undertaken, the standard of care maintained at such rural clinics compares favorably with that in physicians' of-

fices. We believe that can be further improved by limiting reimbursement to those clinics which employ either legally certified registered nurses, or physician assistants, who have graduated from accredited programs.

In summary, then, our various levels of experience have demonstrated the validity of services provided by rural health clinics,

and the need for medicare reimbursement for those services.

I strongly endorse Senate bill 708 and urge the committee and the Congress to enact this, or comparable enabling legislation.

I would recommend that five specific points be either addressed,

or considered carefully.

Although there is need for urban as well as rural clinics—and we have heard testimony to that effect-I support your limitation of S. 708 to rural areas only. I disagree with previous testimony. I feel that rural clinics in fact take a different kind of approach to the medical care problem; to confuse the two issues will in my opinion wind up doing neither task as well as it should be done. As you well know, I have had substantial experience in the past with the neighborhood health centers and urban clinics. I think they are two different systems.

The second point. It should be emphasized in the legislation that reimbursement will be provided under physician supervision with proper protocols. But I would hope that you would not require any kind of formula that would be set for the protocol because the

needs vary so widely between the different communities.

Third, it is recommended that the Secretary be empowered through regulation to determine what training, education, and experience requirements are to be prescribed for nurse practitioners and physicians' assistants that staff the clinics. I agree with previous testimony, the Secretary should take into consideration proper accreditation procedures for those training programs. But I believe—and that is in addition to what I have read, at least—that there may have to be some specific quality control processes in addition to those that have been operative elsewhere, that would emphasize objective peer and patient review of the care given in these clinics. I believe that would be an important addition.

I would suggest that payment be on a cost reimbursement basis and in this I agree with the previous testimony-that the money should be addressed to the clinic itself; and in our rural areas at least present fee for service levels are not sufficient to cover the true costs under the medicare program. I would not object to the deductible; although it is not as useful in these areas as it is in

other circumstances.

Allow me to add a note of urgency—and I will give you a copy of this—some of the clinics in Tennessee have been supported by deficit grants from the Appalachian Regional Commission-and as you saw, I have had the privilege of working with them—that has been furnished in the interim in the hope that the reimbursement laws would change. The Tennessee medicaid law has, but without medicare the clinics are not going to be able to make it. ARC funds, as you know, by law cannot continue for more than 5 years. Clear Fork Clinic, as a specific illustration in Tennessee, will reach that limit on May 1st; and others are going to join them as the months progress.

I join with the 13 Appalachian Governors who last week passed a resolution calling for prompt attention to this legislation, and join them in the feeling that we cannot afford the luxury of accommodating calendars—unless, of course, we are willing to sacrifice a few of the existing clinics.

I thank you again for the opportunity to present the testimony, and if there is anything I can do in the way of responding to

questions, I will be happy to do so.
Senator Clark. Well, it is excellent testimony, and you have made five interesting recommendations. I was particularly interested in hearing your views on the difference between a rural clinic and an urban clinic, as well as the other recommendations.

If we try to look at this problem in a broader sense of health care in rural areas, whether clinics are really the answer to that, and so forth, is it your judgment that it would be preferable for our country to put physicians in every community, regardless of size?

Dr. Wilson. No; nor do I think it is possible. I do not think that

is an issue that centers around reimbursement. I believe you aptly pointed out earlier—or at least in some of the testimony earlier it was pointed out that physicians' families, and the environment that is required by people with that much education tends to work against some of these very small areas. My feeling has been now for quite a number of years that the only approach to this is to find people who lived in the community for other purposes, and help them to achieve the level of understanding that is required to deal with the large number of problems, and to form an effective bond, then, with the health care system.

Although you would have had no reason to have seen it—it was in a different era under a different egis—a term called "Activated Patients" under which some of my friends are still working in this geographic area, which says that much of what goes on in health care should be transferred to patients, if you have the proper educational facility to help them do it. If you look at a labor-intensive industry like health, and if you look at the amount of growth in the gross national product being absorbed by it, it is very clear that we cannot solve the whole problem with the present kinds of ap-

proaches.

The local health clinic, it seems to me, is the place where it is most apt to pay, and its difference from the urban clinic is substantial. The last point I would like to make and that may be hard to grasp, but also may be the most real, is that the rural clinics work in a well-established social structure. They really know who runs the community, and it is a very tightly knit group. If you try to change a rural community from the outside you will quickly find out how tightly knit it is. Unless you use that well-knit structure you probably can do very little for them. The failure of the neighborhood health center approach in rural areas was a good proof of that.

If the approach is reversed by incorporating the social structure into the health care system, then a strong system results. That is what these rural clinics have been doing But you cannot use a physician as the major resource. Someone in the local community must act as a physician contact.

Senator CLARK. Now, you have been involved in medical education, and so forth; what about the new physicians, how well do they take to the idea of physician extenders? I am talking about new graduates particularly, but you may want to talk about other physicians, as well.

Dr. Wilson. New physicians take to it quite readily. They were almost conditioned from graduate and undergraduate work. I think those that are in my age group take a little more adapting, they

have been adjusted to a different scheme.

Interestingly enough, I do not join with the people who view that as an attempt to control; I think it is more an anxiety arising from the fear that poor health care will be given. We were raised in a day when very little was known. My recollection goes back to the time when we did not even have sulfa drugs. We have been raised in an era where we have tried to develop more and more information. We have plenty of information now, and what we need is performance—that is a different kind of a system.

Senator Clark. Is there any trend at all back for doctors to be

distributed—moving in a different way—going to rural areas?

Dr. Wilson. Not for the right reasons.

Senator Clark. Not for the right reasons. You think there is

some change ?

Dr. Wilson. Yes; but as you well know, there are a great many people moving out to escape the urban areas. There are physicians now being distributed into smaller communities. But in rural areas I have seen no reversal of the trend. It is into the less urban areas, I guess, that we are seeing some move now.

Senator Clark. I see. Senator Leahy? Senator Leahy. Thank you, Mr. Chairman.

Doctor, you were here during the testimony of Secretary-designate Warden. I expressed a concern that the program would be set up primarily for rural areas because of the extraordinary problems of rural areas. Transportation is the obvious one—the distance often from medical centers or areas where physicians are established, and the lack of any kind of transportation system in most rural areas for that, and a whole host of other reasons. This concern is one of the things primarily on my mind and the chairman's mind when this legislation was first introduced.

Do you see the concerns for this type of clinic, this type of program, this type of nurse practitioner, physician extenders, whatsoever, do you see that need as being of a different nature in the rural

areas from the urban areas?

Dr. Wilson. Yes; I commented a little bit earlier, so I will not repeat quite all of it, but I think it is distinctly different. I think both problems exist and both problems should be addressed. I do not believe they can be addressed in the same mechanisms, not only because of the issues you have raised, but because of the communities own capacity to take on the responsibility for their own problems, which would give them resources with which to work.

It is not only a transportation issue. The population distribution is an issue; distance to systems of various kinds is an issue. Basically the rural community because it is more closely knit has a ca-

pacity to set standards for performance.

Senator Leahy. You understand my concern that if the program is applied to both rural and urban areas, that we will very soon find the trend, as in so many other things here, the bias on the part of Washington agencies to turn the thing into an urban program, with probably a stepchild appendix for rural areas which may, or may not, work.

Dr. Wilson. Well, for somewhat the same reason, I think it should be two separate programs. I would strongly urge that this be handled as a discreet program, and that the urban areas be ad-

dressed by a different mechanism. Senator Leahy. Thank you, sir.

You recommended control processes. Do you have some specific suggestions or examples?

Dr. Wilson. It is never very polite to use illustrations from your

own background, I guess.

Senator Leahy. Those are the ones you are most familiar with.

Dr. Wilson. In setting up our Vanderbilt primary care clinic we are planning an overview group composed of a 50-50 combination of individuals who receive care in clinics, and the staff who are providing the care. This is to assure that they talk with each other about what transpires in the clinic, as seen by the patient, as well as seen by the professional. As a career professional it is clear that we as professionals see care problems with a somewhat monocular view, our focus is almost totality on the quality of the health treatment given to the individual—whether it is nursing or medicine—we look to see if we did a good thing. That may or may not have been significant from the patient's point of view particularly if he did not understand the reason for our actions, or was not able to carry out what we recommended.

We have a group, a panel of about 15 people, who will be reviewing all transactions, looking at them from the effectiveness point of view as well as from a medical or health care point of view.

Senator Leahy. Are you familiar with the promise of it?

Dr. Wilson. No; but I expect what we are doing is not all that novel.

Senator Leany. Thank you, Mr. Chairman.

Senator Clark. Senator Dole?

Senator Dole. I am in the process of reading your statement. I am sorry to be somewhat late. I have no questions. I do have a statement, Mr. Chairman, and I would like to have it inserted in the record.*

Senator Clark. Fine.

We want to thank you very, very much for sharing your long experience and views with us, Dr Wilson.

We are going to turn now to a national rural panel, if you would

come up to the table.

I might just tell you about some of these people as they come up. Faye Henning is a nurse practitioner involved in public health since she graduated from nursing school in 1950. She was the first nurse practitioner to be trained in family planning in Georgia; holds a BSN from the Medical College of Georgia, and is a cer-

^{*}See p. 119 for the prepared statement of Senator Dole.

tified nurse practitioner, pending certification as an adult health nurse practitioner.

Also, we have Rebecca Cornish. Rebecca, you are accompanying

Faye, I think. Also Penny Dykstra.

Bob Ewell, director, Tri-County Health Services Commission in Oregon, which operates three clinics in northeast Oregon. The project serves a three-country area with the clinics, a home health agency and a homemaker service. I think he also acts as liaison to other community and State agencies.

Dr. Corbett, Eugene Corbett, director of health services at the Central Virginia Community Health Center in New Canton, Va., and assistant professor of medicine at the University of Virginia. He holds an M.D. degree from the University of Chicago, and

worked at John Hopkins.

David Walston is a physician assistant at South Plains Health Providers Organization, Plainview, Tex. He is a graduate of the University of Texas Health Science Center at Dallas' physician assistant program, and has been practicing as a physician's assistant in Plainview for 7 months.

I think what we will do, we will take your statements as prepared and put them in the record at this point, and then, if each of you wants to make a statement you can do that in turn; and then

we will question the panel together.

So, let us start first with Faye Henning.

STATEMENT OF FAYE HENNING; ACCOMPANIED BY REBECCA CORNISH AND PENNY DYKSTRA, NURSE PRACTITIONERS, ATHENS, GA.

Ms. Henning. Mr. Chairman and members of the committee, in Georgia there are 159 counties, the majority of which are rural, 137 are medically underserved. In the northeast Georgia health district, where I work as an adult health nurse practitioner specializing in women's health, we serve 10 counties. Eight of the counties in our district fall into this category of being medically underserved.

The 10-county area, 61 percent of which is rural, serves a population of 200,000. Ten percent are over 65 years of age. Eight percent of this 200,000 receive public assistance. The average per capita in-

come is \$2,100 per year.

Nurse practitioners have been an integral part of providing primary health care in the northeast Georgia health district's county health departments for the past 5 years. Due to the maldistribution of physicians in our area, we had two counties without physicians and one county had a physician part time. Three of our counties are without hospital facilities. In Clarke County, the most heavily populated county, we tried to recruit physicians to work in our health department clinics, but they were unable to spare the time from their overloaded practices.

In 1970 a public health nurse, functioning in the traditional nursing role in one of our rural counties was able to serve only 24 patients per year in a women's health clinic because a physician was not available in that county. To receive medical attention these

women had to drive into Athens, 25 miles away. With the addition of a nurse practitioner in this clinic, the number of women being served has increased from 24 in 1970 to 2,070 in 1977. We now are able to serve women in this county regardless of their socioeco-nomic level who have not previously had access to health care some of whom had not seen a physician in 18 to 20 years.

Moreover, for the entire 10-county area a 275-percent increase in the utilization of women's health clinics has occurred since nurse

practitioners were added 5 years ago.

By utilizing nurse practitioners in our area, I know we have made an impact on health care. Individuals have found health care for their specific needs and we have provided the point of entry for these indi-

viduals into the health delivery system.

In addition to these women's health clinics and other health department programs we have had one primary health care center functioning for the past 5 years. Two more primary health care centers are opening April 15 under the Federal Rural Health Initiative Grant. These new clinics will be operative on a fee-for-service basis and must be selfsustaining in 3 years. Without medicaid/medicare reimbursement the patients who will be utilizing these clinics will be back in the same situation they were in the past.

Many individuals with high blood pressure, chronic respiratory diseases and cardiac problems will have to continue to live with their discomforts, untreated, as they have done in the past. There will continue to be an increase in heart disease, cerebrovascular disease, cancer and reproductive mortality—the leading causes of deaths in Georgia. Nurse practitioners can make a significant impact in decreasing the morbidity of these conditions by providing care that focuses on early detection, health maintenance and prevention through effective patient teaching and counseling. The accessibility and effectiveness of our health care systems determine the health of our citizens. The quality of life for all of us is directly or indirectly related to our investment in health care.

We support the concept of this legislation which will supplement rural health programs. This supplementary assistance is particularly timely in that we are experiencing a migration of the younger populous from rural areas to the larger communities for employment. This leaves a larger population of elderly, who are experiencing greater health problems, living on fixed incomes. All of these factors result in a shrinking tax base on the local level. Consequently as health care needs are increasing, the economic ability of local community leaders meeting these needs is in fact decreasing.

Referring the rural populous to larger cities for health care does not address itself to the problems of transportation. With the lack of public transportation and reduced numbers of individual vehicles, rural citizens are not able to attend distant medical facilities if

an emergency condition does not exist.

Certainly, from a humanistic and economic point of view, rural citizens should have access to a basic level of health care in their own community. This proposed legislation would allow community leaders and health providers an opportunity to implement and sus-

tain programs at the local level.

This bill is a move in the right direction to reduce some of the existing barriers to providing rural health care. However, while developing this legislation careful consideration must be taken against introducing new barriers. For example, if nurse practitioners must be certified as adult-family nurse practitioners by the American Nurses Association, then only one nurse practitioner in Georgia would qualify to receive funds at this time. This would in effect deter the very purpose of this legislation. Nurse practitioner educational programs have only been available for the past 5 years in Georgia. The ANA has only had certification for adult-family nurse practitioner since fall of 1976. The certifying examinations in the various areas are offered at irregular intervals, as far apart as every other year. The proposed legislation limits those nurse practitioners who are specialized, such as the OB-GYN and pediatric nurse practitioners who want to take their certifying exam in their area of specialty.

I would also like to address myself to the term "physician extender" as used in the proposed legislation. This term may be a problem in the future because health care providers other than nurse practitioners and physician assistants fall into this category. I would like to suggest that the term "health care practitioners" as used by Mr. Church in his commentary would be more consistent

and acceptable.

Let me conclude by expressing my appreciation for the opportunity to testify.

Senator Clark. Well, thank you very much.

I think we are going to hear next from Bob Ewell.

STATEMENT OF ROBERT C. EWELL, EXECUTIVE DIRECTOR, TRI-COUNTY HEALTH SERVICES COMMISSION, HEPPNER, OREG.

Mr. Ewell. Thank you, Mr. Chairman.

Mr. Chairman, it is a privilege to appear before you today to address one of the greatest inequities in our health care delivery system, to those older Americans who live in the rural and sparsely populated areas of our country, that of the inability of physician extenders, who are now providing a large proportion of primary care to these areas, to receive reimbursement from medicare for health care services performed.

The Tri-County Health Services Commission is a consortium of three individual counties in eastern Oregon which have been working in cooperation with each other for a number of years to improve the accessibility and availability of primary care to its residents.

In order to provide insight into the necessities of amending title XVIII of the Social Security Act, I would like to provide a back-

ground of our experiences.

The three counties that we serve cover a large geographic area with a sparse population where it is necessary to travel great distances over poor country roads to receive primary care, and even

greater distances to receive secondary and tertiary care.

In order to provide primary health care on a local basis, assistance was requested from the National Health Service Corps to recruit and support adequate health personnel to staff primary care facilities in each county.

Each of the counties involved provide the moneys necessary to construct facilities in which these individuals would be able to establish a practice.

Two of the facilities, in Wheeler and Gilliam Counties, were equipped with X-ray, basic laboratories equipment, and trauma rooms, due to the fact that none were available within a reasonable

distance.

The third facility, in Morrow County, was located adjacent to the hospital for two reasons: One: To reduce the cost of the clinic construction by not having to install X-ray and trauma rooms. Two: To increase the income of the hospital by utilizing the existing X-ray and trauma facilities.

The initial clinic to be staffed was in Wheeler County in 1973. The second clinic was in Gilliam County in 1974. Both of these were staffed by National Health Service Corps family practice phy-

sicians. They were assigned for 2-year periods.

The operating budgets for the clinics, excluding provider cost, were placed in the counties' general fund with fees for services reverting back to this fund with the intent that by year end income

derived would equal operating expenses.

Due to the fact that the physicians did not have the capabilities to perform tests and procedures for which they were trained because of the unavailability of financial resources to acquire the necessary equipment, and were not able to follow individuals who required in-patient hospitalization, the utilization of the clinics were quite low. It was felt by the area residents that it would be a duplication of costs to go to one provider and then have to be referred to another with basically identical tests being performed.

With the low utilization it proved to be very difficult for the phy-

sicians to establish a financially self-supporting operation.

When the physicians' 2-year terms with NHSC expired, both moved from the rural area to relocate in an urban setting. This left

us again with a health manpower shortage.

Again, assistance was sought from the NHSC to staff the vacant clinics. It was at this point in time, 1974, that the role of physician extender was becoming increasingly important in the delivery of primary health care.

Our first family nurse practitioner was recruited for Wheeler

County in 1974.

A large public awareness program was instituted to inform the residents of the role and scope of care and treatment that a nurse practitioner could provide. The acceptance of the NP by the people was beyond our expectations. Utilization of the clinics increased overnight, and this utilization has remained in a continued increase.

Based upon our experiences in Wheeler County, when the physician left Gilliam County, another NP was recruited to staff that

facility, and the same growth has been experienced there.

Realizing that physicians were still required as an integral part of the system, the new family practice physicians were recruited locally in 1975 to staff the Morrow County clinic. These physicians, in addition to one that already had an established practice, were the beginning of an integrated health delivery system development with NPs staffing the rural outpatient clinics and the physicians

being established in Morrow County, located adjacent to the sec-

ondary care hospital.

These physicians provided the preceptorship required for the nurse practitioner and traveled 1 day a week to each of the clinics for continued education, patient protocol, and chart review.

This system has been of great benefit to all of the residents because the physicians are able to treat the secondary and tertiary levels of illness/diseases for which they are trained, and the NP's

provide treatment for the primary level of care.

As stated previously, the public acceptance of this system has been great, however a number of major problems have developed that are putting definite limitations on the ability of the system to be able to continue

Currently NPs are not recognized by medicare as health care providers and are thus unable to be reimbursed for care and treatment provided. This has forced a large segment of the senior population—which is 18 percent of our total population—who are medicare eligible, to travel to larger towns where they can be seen and treated by a physician, thus utilizing their medicare benefits. This process increases the indirect health care costs to the senior citizens in total.

At one time the physicians were willing to sign the medicare insurance forms. This practice had to be terminated because when the printout of medicare payments was made at the end of each year, this income was credited to the physician where in fact when the physician received the check he endorsed it and forwarded it to the appropriate clinic. A recent article in the Portland Oregonian depicts this in much more graphic terms, and I included the article as part of my testimony.

A growing number of private insurance companies—First Farwest, Western Farm Bureau, Beneficial National Life, Blue Cross, and Equitable, to name a few—have recognized the role that the nurse practitioner provides in the delivery of health care in rural

areas, and reimburse the nurse practitioner as such.

Nurse practitioners are a vital and growing link in the delivery of primary health care in rural areas of America, where physicians

are unable or unwilling to establish medical practices.

The State of Oregon nursing division has recently adopted administrative rules and regulations to govern nurse practitioner activities. Provided with established scope of practices and treatment limitation guidelines, the nurse practitioner role can increase.

A great deal of concern has been expressed for cost containment of our rising national health care bill. Through the enactment of the proposed amendment to title XVIII of the Social Security Act.

this will have a definite effect on the health care costs.

With a major segment of our citizens, the older Americans, being deprived of the accessibility to adequate, low-cost primary care, I urge you that this amendment be passed out of your committee with a strong note of support and endorsement for its passage by the full Senate.

Through the passage of this amendment, rural America will take a step closer toward having and receiving the health care to which they, as Americans, are entitled. Thank you, Mr. Chairman.

Senator Clark. Thank you very much, the attachments to your statement will appear in the record.*

Dr. Corbett is our next witness, have a seat doctor.

STATEMENT OF EUGENE C. CORBETT, JR., M.D., CENTRAL VIRGINIA COMMUNITY HEALTH CENTER, NEW CANTON, VA.**

Dr. Corbett. I am a rural physician. I was born and raised, as well as educated, in the city. I generally support this legislation because I think it represents a step in the right direction.

I work out of a rural community health center, which was originally funded by OEO, and is continually funded by HEW. We generally have a setup in a 1,200-square-mile area in central, rural Virginia where there is no transportation; there is a lot of unemployment; at least a third of the families do not have flush toilets or running water; there is barely any medical service available; the nearest hospital is 50 miles away, and the medical service for those people is gradually diminishing.

By virtue of the neighborhood health center that was established there, comprehensive medical service is available and is being delivered with the combined efforts of nurse practitioners as well as physicians. We work out of five facilities—a central main facility and our satellite facilities. The satellite facilities are being staffed 3 days a week by nurse practitioners and 1 day a week by a physician;

I have more details in my testimony.

With regard to this legislation:

First of all: It is an obvious source of reimbursement to pay for the services that the people need. The services are not paid for that are performed by the physician extender and what we are asking here is that the legislative mandate change, so that the people's tax money can be used to pay for the services that many pay for out

Second: I think the results of legislation like this will be to increase the absolute availability of services; doctors do not need to provide all the services. Services can be provided by many more people than the doctors. There is a large manpower pool that is available now, nurse practitioners and others, physician extenders,

and we ought to legitimize that now.

Third: The types of services that would be available if these kinds of legislative efforts were successful would increase, especially in underserved areas. It would mean that a lot of the more complex and less than simple care that is needed by people—whether it is in the country or city—can be provided by the doctor. If I live in the country and have a nurse practitioner or physician extender, I can probably do much more and do a better job than if I were out there by myself.

Fourth: In our situation in rural Virginia, we try to bring a lot of traditional hospital services to people who live out there, something that can easily be done if you are competent. You do not have

^{*}See p. 126 for the attachments to the statement of Mr. Ewell. **See p. 138 for the prepared statement of Dr. Corbett.

to follow the traditional patterns of medical practice that some of our urban colleagues would have us believe. A doctor can provide more service in the country if he has help. He can take care of people who are at home who, if they were living in a city, would be hospitalized. Many rural people, if they get ill, will not go to the hospital anyway. If you want to take care of them properly, you cannot do it by yourself, whether you are a doctor or physician

Fifth: And this is derived from my previous point. If you can provide a lot of the services that are currently done in hospitals, in the community, it is much cheaper, and it can be done just as well if there is a competent effort among a variety of health practitioners,

including physicians.

Sixth: I think this legislation is a step in the right direction because it encourages reimbursement for service provided rather than emphasizing who provides it. If we can insure that there are proper safeguards, it really should not matter whether it was done by a doctor or a physician extender. I think doctors should set the standard for care so that any care that is provided is based on basic medical science which we now have; but I do not think he needs to do it all himself.

Seventh: Let me just make a point here on what are the basic quality safeguards that are needed in this piece of legislation. If there are many more than this, it will be overly restrictive; and if there are less, I do not think it will be enough. (1) The standard of care for any practice—whether it is a doctor practitioner, or physician extender—is producible; that is, they can demonstrate that they are doing exactly what they say they should be doing; (2) that a definite link has to exist between a physician and a physician extender, for consultative, referral, and care purposes; (3) that a doctor is available to the physician extender whenever the doctor extender needs help; (4) that an appropriate and decent medical record be maintained; and (5) that the provider—whether he is a physician or physician extender—complete a basic training program, as well as having board certification and/or licensure to

Eighth: I think the effect of this legislation, and I am speaking from a very personal standpoint, would be to encourage more rural doctors. I think there would be more rural doctors if they were able to provide care for those things for which they have been trained; but right now we have training programs that focus on disease and complex care that somehow never relate back to the person that needs that care. I think it would be a double standard if we developed a system where in the country you get the care from a physician extender, whereas in the city it comes from a doctor.

Ninth: It does not make sense to have training programs—including many that are paid for by Federal funds now—producing providers, people who give primary care now, if we do not allow for the reimbursement mechanism to pay for what they are being trained to do. That is one of the inconsistent aspects of the Federal

approach to solving community health problems.

Tenth: The kinds of services that can be provided by a physician extender depends basically on the competence of the individual; depends on how they are trained, and also depends on their doctor. In our setting a nurse practitioner can do a considerable amount of pediatric and adult well care, can take care of a lot of the things that a competent grandmother used to do, with some training. They provide some of the family planning services, pre- and post-natal care; and they also provide care to people with chronic, long-term illnesses. I might give an example of that. If I had a patient with diabetes or a heart condition, as long as their condition is stable, as long as they are doing well, I do not need to see them two or three times a year. I think they need to be seen two or three times a year to assure that we keep them out of the hospital and provide them with what they need; for as long as they are doing well, they can see the nurse practitioner that I work with. She is competent, she can recognize when they are ill and when they are not; and I do not have to be looking over her shoulder.

And one of the most important points, I think, as long as proper safeguards are followed, I do not think we need this provision, this restriction, where the physician extender has to be right next to the doctor. As long as the practitioner is competent and the quality safeguard exists, and the physician is available, I think they could do a comparable job in many instances—but not all.

Lastly, I have a little bit of trouble with this piece of legislation if it goes through, stipulating rural physician extenders be reimbursed, but not all physician extenders. I think it is going to add to this double standard kind of system we seem to be developing. At the present time, if a physician in the city wants to expand his ability to provide services, unless he is going to be physically with somebody, he has to hire another doctor. I think if we had more recognized practitioners, recognized that more people can take care of patients than just doctors, I think we could probably get more doctors out in the country because the urban demand would begin to diminish. I think there would be no problem getting doctors out in the country if we could remove some of these restrictive aspects that keep us from having reimbursement for services that people who are competent provide. As well, I think, there is a need to change the attitudes in medical schools.

That is pretty much the sum and substance of my testimony. I just want to close by saying that rural people ought to have the services of rural physicians, as well as physician extenders. I think that better care can be provided by both of them working together

than by either one of them working alone.

Senator Clark. That is a good statement, we appreciate it very

Now, the last panelist, before we start the questions, is David Walston, who is a physician extender. He is accompanied by Jim Clayton, the project director of South Plains Health Providers Organization, Plainview, Tex.

David Walston, you have 5 minutes to summarize, your full state-

ment will be a part of the record.*

^{*}See p. 143 for the prepared statement of Mr. Walston.

STATEMENT OF DAVID E. WALSTON, PHYSICIAN ASSISTANT, ACCOMPANIED BY JIM CLAYTON, PROJECT DIRECTOR, SOUTH PLAINS HEALTH PROVIDERS ORGANIZATION, INC., PLAINVIEW, TEX.

Mr. Walston. Thank you.

South Plains Health Providers Organization is a nonprofit organization, funded primarily by funds from the Department of

Health, Education, and Welfare.

Through our central clinic in Plainview, Tex., and three satellite clinics, we provide comprehensive health care to over 16,000 patients in the rural area of the Texas Panhandle. Many of these patients are medicare eligible, and the number of medicare patients is in-

creasing daily.

Our organization serves a 10-county area of the Texas Panhandle, and most communities have populations of approximately 5,000 or less. Those townships experience the same crisis that most of rural America currently feels; this crisis is the lack of rural health facilities, and the nonavailability of trained medical personnel. We are alleviating that problem for a small percentage of our population. On an average day our clinic facilities see approximately 200 patients; and by the end of an 8-hour day are turned away and told to come back tomorrow.

In order to meet the growing needs of our patients, it has become necessary to use physician assistants and nurse practitioners as primary health providers for many of our 16,000-plus cases. These trained professionals work both in our central clinic and in the satellite clinics. Their effectiveness and success in delivery quality health care has been demonstrated much to our satisfaction. Their knowledge in medicine and judgment involving medical decisions is strongly endorsed by physicians; and the working relationship between physicians and physician extenders is of the highest degree.

We have barely scratched the surface of the medical needs of our rural population. Our patients depend upon us simply because medical care is not available from any other source. There are countless others who cannot make it to our clinics, who deserve the same

care.

We have found physician assistants and nurse practitioners to be the most positive factor, and at the same time the most efficient in delivering health care to the rural community. Many medicare patients live in these towns, and often must travel over long distances to find facilities that will accept them as patients.

The satellite clinics are staffed by qualified physician assistants who make such medical care more accessible and more feasible. In addition emergency care would be available in most communities where neither a doctor nor a nurse resides, and where time spells

life or death for a heart attack victim, for example.

Our physician extenders would also be available to provide coverage for nursing homes, some of which in our area have not seen a physician in several months. We are obligated to maintain the health of our elderly in nursing homes, and not to sweep them under the rug to be ignored.

The South Plains Health Providers cannot fulfill our role, to which we are dedicated. We cannot provide the health care where it is needed most without the utilization of physician assistants and nurse practitioners. This utilization depends upon the utilization of medicare support of its services which fall within medicare reimbursement.

We support the current proposal to change the existing policy and allow for such payment. The medical needs of our rural popu-

lation are at stake and they cannot be ignored any longer.

Thank you for the opportunity to testify on behalf of our orga-

nization, and the rural population of northwest Texas.

Senator Clark. We thank you and the other panelists for your very good statements. We are going to go now to the questioning.

Senator Dole?

Senator Dole. I have taken a look at S. 708, not as much as I will, but I think it does have some possibilities. In our State we do not have in operation any of the clinics that might be reimbursed under this bill. What about your physician assistants, are you supervised by a physician? Would you be reimbursed under this measure?

Mr. Walston. I would think not. I think the reimbursement would go directly to our clinics, or to the physician to whom I am

responsible.

Senator Dole. The question I raise, I think if we limit reimbursement to clinics, I think we may not serve the purpose we have in mind. That is my view. In our State this bill would not be of any benefit at all because we have no clinics as such, to be reimbursed.

Mr. Walston. The reimbursement could apply to the private physicians to whom the physician assistants are responsible.

Senator Dole. It could, but I do not think it does under the present drafting. It is my understanding the reimbursement is only to clinics.

Senator Clark. You said only to the clinics, Senator Dole?

Senator Dole. Right.

Senator Clark. Under the present law—and someone correct me if I am wrong—under the present law, if a physician assistant works under a physician that physician would be reimbursed. Now, under this legislation it is true, if you have a rural clinic and the physician is not connected with that clinic and is in a supervisory role in another town, then the reimbursement would go to the clinic, rather than to that physician.

Senator Dole. Is it drafted that way?

STAFF. A physician practicing under our bill would be considered a clinic, if he abides by the requirements that are set out under the bill. That would be especially helpful to physicians who utilize physician extenders or nurse practitioners, but do not supervise them directly. So, I think it might be of help to those physician practitioners in Kansas.

Senator Dole. We want to look at that. There will be some witnesses later on—and I will not be able to be here—who raise similar questions because it is going to be useful if we make it broad enough, to apply to those who want to participate. I think you raised one

of those questions.

Dr. Corbett. If you try to increase availability of service to poeple, if you have the kinds of safeguards I mentioned, it seems to me the reimbursement should go to whoever is responsible for administering the practice. If it is the clinic, it should be the clinic; if it is the private physician, I think he should be encouraged to be able to take advantage of it, also.

Senator Clark. Good.

Senator Dole. That is all I have. Senator Clark. Senator Leahy?

Senator Leahy. I noticed in the testimony of Dr. Corbett on page 7, you stated the third reason why this legislation makes sense is because it would enable us to focus more on the type of care provided than on the type of practitioner providing that care. I think really in many ways, Mr. Chairman, that sums up the whole reason for us being here; the whole reason for these hearings. I know some of this testimony bogs down on semantics questions, terminology used, just particularly what the person delivering the health care is called, even though a lot of the testimony refers to precisely the same type of activity; yet, the whole thing comes down to what type of care we are providing. Right now it is very much of an "either or" type of care in rural areas. Either we give them something along this line, or no care at all.

I expressed concern to one of the other witnesses earlier that we shouldn't tie rural and urban problems because of the vast differences in transportation, population density, and everything else. And if we do what was suggested by the administration witnesses, set a certain amount of money for rural areas and a certain amount of money for urban areas, trying the same program in both places, it is my feeling that very soon the rural part of it will be forgotten

and will become all an urban area.

If anyone disagrees with that point, state your disagreement

and the reason for it.

Dr. Corbett. I think if you look at the legislation, you can make a lot of changes, and I think that is probably not good. I do not think the legislation can make all the kinds of changes you just summed up. I think what is important is to make it less restrictive so that, whether it is urban or rural, the people get the services

they need, and then reimburse for them secondarily.

All sorts of things come to mind with the question—there is a lot at stake here. One of the problems with the existing health care systems seems to be—and maybe I am overstating it—that right now, except for in-hospital care, we almost mandate that the doctor does all the providing outside of the hospital; and in the city that is not any more necessary than in the country. And there is really no incentive to try to broaden the availability of services.

Senator Leahy. So, the emphasis on this bill would be providing it in the rural areas, or providing it in the urban areas, if it came

to an either or situation.

Dr. Corbett. I cannot agree with that, it cannot be limited to one. Senator Leahy. Well, it is going to be limited to some extent because it is going to be limited by way of the funding mechanism.

Dr. Corbett. In that case I would suggest that the rural areas, the underserved areas have first priority, whether rural or urban,

and not have that available in areas where there are plenty of

doctors.

Ms. Henning. As the doctor pointed out, the urban areas have the political mechanism to get care, and the need is out in the rural areas. We are not as politically oriented and could wind up with less care.

I have a friend who would like to comment.

Ms. Dykstra. I have some concern also because of the fact that educational programs for nurse practitioners and physician assistants are set up with the idea of providing more health manpower, and what we are talking about here is taking care of people who cannot get care otherwise. Providing the same funding to PA's and NP's in urban settings will only encourage PA's and NP's to seek jobs in an urban environment which seems self-defeating to the original intent of PA and NP programs.

Senator Leahy. That was exactly the point I was going to raise to Dr. Corbett, the point he makes on page 12, that we should restrict reimbursement to rural clinics. But, do we not then run the very grave risk that if physicians and extenders are given the choice of going into rural or urban areas, that they are going to

choose the urban areas?

Dr. Corbett. I think so. I think rather than saying rural versus

urban, we should say underserved versus served.

Senator Leahy. But then comes the question of what is the definition. If you use the definition that underserved is an area where the population, the bulk of the population does not have a significant medical facility within 20 miles, then no urban area is underserved. I mean, you can define it however you want. If people, a certain amount of the population is not getting adequate medical care, however defined, you can bring in a lot of urban areas. The question then goes to not the availability but the motivation, the education, the money available—with motivation and education probably being the biggest problem.

So, then it is going to come down to the question of terminology of what constitutes an underserved area. If it is distance to facilities, then all is going to the rural areas and none to the urban. I mention that again in the context of my own particular concern that if we make it a rural-urban program that because of the political realities and the fact of the myopia that exists in Washington—the myopia that tends to have us reflect only on urban problems—that the rural

areas are going to be continuously underserved.

Dr. Corbett. May I respond to that?

Senator LEAHY. Sure.

Dr. Corbett. Neighborhood health centers get fairly comprehensive funding. So, we have a situation here where we are receiving funds for reimbursement of nurse practitioners who provide care for patients. I think it is interesting that in our area, which is very rural, since the health center was developed, three or four physicians have moved into the county, and there are more nurse practitioners than doctors; but there are no nurse practitioners living in the area.

Senator Leahy. Living—

Dr. Corbett. There are no nurse practitioners living in the area that we are mandated to serve by the HEW guidelines. I just think it is a step in the right direction of helping to lessen that effect.

I think as long as we think in contrasting urban versus rural—what we are trying to do is get service for people that need it. We can divide it up into the areas that are underserved and are served. There are already plenty of Federal guidelines that indicate the areas that are underserved. There are HEW guidelines county by county, the ratio of doctors to population. Maybe we should make a point of primary care providers versus population. We should have some restrictions and limit it initially to areas that are underserved. I just do not think it is fair for people in general to have that kind of restrictive approach. The services are aimed for the needed areas first, rural and urban, and exclude those that are already well served.

Senator Leahy. Thank you, doctor. My last question, you mentioned that we were creating new barriers by requiring adult family

nurse practitioners certified by the ANA; could you explain?

Ms. Henning. Yes. I believe we need certification, but if you say only nurses that are certified as adult family practitioners may be reimbursed, that means that nurses like me—or OB-GYN nurse practitioners—who are working out in the rural health department field with people who are over 65, that I would not get reimbursed for that service.

Senator Leahy. I understand this question of maintaining— Ms. Henning. You know, any nurse practitioner should be able

to receive reimbursement, not only adult nurse practitioners.

Senator Leahy. But how do we maintain some quality control? Ms. Henning. You see, if you say that a nurse practitioner cannot be reimbursed until she has ANA accreditation, then that means that we only have one or two nurses in Georgia that would receive funds, at the present time. I think down the road that is a step in the right direction. But I feel that if a nurse, nurse practitioner, or physician assistant has passed the examination of the program, then she should qualify.

Senator Leahy. But you agree there should be some standard.

Ms. Henning. I certainly do.

Ms. Dykstra. I want to also comment on that. I agree that there should be certification. And ANA, as they become more involved in the testing procedure and have more tests available, this may be applicable. But right now you get family or adult; and the people who specialize in OB-GYN, like Faye does, they cannot take their exam in OB-GYN and qualify for funds. Now, some States also have examination by the board of nursing, which is jointly overseen by the medical board and the board of nursing, and they provide certification at the State level; and some people foresee that, and not ANA certification.

Senator Leahy. Thank you, Mr. Chairman.

Senator Clark. Mr. Ewell?

Mr. Ewell. Senator, Oregon has taken that role, and we have under the guidelines of the board of nursing developed rules, regulations, and guidelines under which nurse practitioners can be certified, nationally certified and State certified. We included nine categories, family nurse practitioner, pediatric nurse practitioner, adult nurse practitioner, geriatric nurse practitioner, psychiatricmental health nurse practitioner, nurse-midwife, women health care, rural health nurse practitioner. The guidelines and rules under which they can operate in an expanded specialty role is well defined by the State of Oregon and well controlled; continued education, peer review that is necessary in order to work. In our particular area it is unpractical and unfeasible—both financially and time wise—to have positions in clinics that serve a very basic population

The nurse practitioners are extremely well providing that initial line of primary care and referring the patient to physicians that

are located all in a basic "hub" area.

Back to the basic statement whether it should be rural or urban, I would have to support rural first. Without these clinics, we have individuals that because of unavailability of reimbursement from medicare for services performed, that would mean that the senior citizens who are now receiving care within 34 miles of our clinicsand that is the basic radius of our clinics-would have to travel upward of 160 miles just to see a primary care physician.

We have tried to locate physicians in these towns, but they did not stay. With National Health Service support they were paid; the counties paid all the operational expenses, so there was no outof-pocket expense for the physician; but the minute his term is up

he leaves.

In our testimony we have included charts that show the different utilization between a physician and a nurse practitioner in the same clinic he has gone in the urban setting. We have tried desperately to get physicians in the rural setting, and they have come in a group, but they all practice in the same rural setting that has hospitals and secondary care facilities but not into rural areas.

Senator Leahy. I would like to have a copy of the Oregon law

and standards, if you have it.

Mr. Ewell. They are in the back, sir. Senator Leahy. They are. I overlooked that. Mr. Chairman, I would like to have that placed in the record. I think we agree that some kind of standard is going to have to be set. But I also think we are going to have to realize that it is nontraditional, but substantially better than what we see in some areas of "traditional". I suspect in setting the standard, we are going to have to keep that in mind.

I have no further questions, Mr. Chairman.

Senator Clark. Senator Bellmon?

Senator Bellmon. Thank you, Mr. Chairman. I was not able to hear all our witnesses, but I have a couple of questions I would like to direct to Dr. Corbett. You mentioned, Dr. Corbett—and we all agree there is a need for more rural doctors you said in order to get them we have to change the attitude of the medical schools. Specifically, what did you have in mind?

Dr. Corbett. The situation I see as a result of the training that

I have been through, is that right now most of the influence that bears on the training of a doctor is oriented toward patients in the city, having hospitals, and dealing with the most complex diseases—and that is not a new process, that has been taking place

for years, that did not happen overnight.

The reimbursement mechanism tends to keep a doctor in the city. And I think doctors do not want to come out into the country because they do not understand how nice it can be to practice out there. I am satisfied in my ability to provide care. But I think one of the problems is that medical students are in the city, they do not have dialog with anybody outside of the immediate area. And there is a tremendous tendency for someone like myself who enters medical school, who lives in the city, to have all the right kinds of credentials that look better on applications. But also, a lot of doctors who I have encountered have always worked in that hospital or somewhere in that immediate area. They have never worked in the country. And one of the problems is, I think, that the medical profession is out of contact with the people. So, I think there is a large attitudinal gap.

I think there has to be a change within the profession, but I do

not know how you would change that.

Senator Bellmon. Well, I have an idea that I want to get at in a roundabout way. It seems to me if we take a young person in a rural area, send that person to the big town to go to medical school; bring the person in contact with urban environment with all the sophisticated equipment that is around in big hospitals where they practice; we expose him to the cultural climate in the city. He is probably married to an urban spouse—because most marriages seem to take place during that time—and the chance to get that person back to the rural area is almost zero.

Dr. Corbett. I think you are absolutely right.

Senator Bellmon. Now, we have just established here in Washington a medical school for the military services. I am curious if we do not need somewhere in this country some medical training facilities that are developed in a rural setting, staffed by rural people, that have a rural cultural environment rather than a city environment, that concentrate on the kind of practice that rural practitioners are going to deliver, and the kinds of equipment they have available; and maybe hope that some of those folks would stay.

Would that be a way of solving the problem?

Dr. Corbett. To me that is extremely possible, if we could encourage the training program to involve going out into these areas and working with doctors.

Senator Bellmon. But is it realistic to expect an existing medical

school to ever set up such a program?

Mr. Ewell. Certainly.

Senator Bellmon. It is possible?

Mr. EWELL I do not know about the Nation, but the University of Oregon Medical School is establishing such a program with their family residency practice. We are sending two physicians each year out of those that are in their senior residency, out to the rural areas to work 1 year.

Senator Bellmon. Two of how many? How many are there in a

class?

Mr. Ewell. There are only 11 in the senior residency class. We are trying to get an additional appropriation from the Oregon Legislature this year, trying to expand that program. However, at the present time these two physicians go to the rural areas and work with rural physicians in a rural setting for a year in their senior program, instead of an urban setting and universities. We are hoping they will see advantages to establishing practices in rural areas.

Senator Bellmon. What are the results?

Mr. EWELL. This is our first year for the program.

Senator Bellmon. How many others have such programs?

Mr. Ewell. I am not aware of any.

Senator Bellmon. It strikes me that our whole medical education system in this country is urban oriented; and I do not see any way to take the existing system and redirect it. I talked to our medical people at the university, and they do not even realize the problem,

they do not show any interest.

I am trying to get to another problem, also. I had a bill in last year, which was S. 1897, trying to compensate for the medicare provisions, which seem to me to be discriminating badly against the rural health care delivery. It would have provided that 100 percent of the usual, customary rates to be paid in health scarcity areas—whether they are urban or rural. But in those areas where there is a scarcity of health care delivery, their rate to be compensated would be at 100 percent of the usual customary rate, and in all other areas it would be 85 percent. The bill did not move.

Do you have any reaction to this kind of procedure? In other words, what we would be saying to the physicians, if you go where you are needed, we will pay you 15 percent needed under medicare and medicaid, than if you go where there is already an abundance

of health care.

Ms. Henning. I think you might find in the long run, sir, that it costs more to get health care out to the rural areas than in the urban areas.

Senator Bellmon. Well, I think then we ought to pay a little

more.

Ms. Henning. Well, I think that you will find rural health care in the long run will cost more.

Dr. Corbett. I do not think it costs more to provide the same

service in the country than in the city.

Senator Bellmon. I do not think you understand my point. I am saying a physician, or nurse practitioner, or physician extender who will go to a health care scarcity area will be compensated at 100 percent of the usual customary rates; and in areas where there is not a scarcity of health care delivery, the rate should be 85 percent. That would give them an incentive to go where they are needed. It does not have anything to do with the cost of health care.

Dr. Corbett. I think that is a sensible alternative. I have been trying to think how to add an incentive to go to needed areas. I

think that is a sensible approach.

Mr. EWELL. I am not sure how it is in your area, but in Oregon the reasonable customary rates are higher in the urban areas than they are in the rural areas. You know, that 15 percent would not—

Senator Bellmon. We could make it 30 percent. We thought that 15 percent would be a good starting point.

Mr. Ewell. Yes, it would be a good trying point.

Senator Bellmon. The way the system works now, a young person finishing medical school looks at the rate of compensation, and in the city it is higher than for the same procedure in the country. So, obviously they go to the city, rather than where there is a need. It looks to me like we need to reverse that, saying you will get paid more in the area where the delivery systems are scarce than in the area where they are adequate.

Do you see anything wrong with this? Maybe the 15 percent is

not the right differential.

Mr. EWELL. No, I think that would be a good procedure to attract physicians to the rural areas.

Senator Clark. Now it is just opposite.

Senator Bellmon. That is right.

Ms. Cornish. I am not sure that is the solution in Georgia. I am now working with three primary care centers that are staffed by nurse practitioners. In those three centers we serve 30,000 people, and there are four physicians total in three counties which we serve. None of them accept medicare patients because they feel the reimbursement rate, whether it be 85 percent, 95 percent, or 100 percent is still not enough to compensate them for the extra paperwork and staff. I do not think another 10 or 15 percent is going to influence them that much.

So, right now in our primary care center we are the only people who are serving medicare. There is one physician for 15,000 people, and he is not accepting medicare patients. So, I am not sure whether another 10 or 15 percent would make him change his mind.

You know, it is the whole medicare system, it is universal.

Senator Bellmon. You have a very unusual situation there, do you not?

Ms. Cornish. No.

Senator Bellmon. There are not many places where physicians

are refusing medicare patients.

Ms. Dykstra. In our urban city, Athens, which has a population of 60,000, the OB-GYN men in that town will not deliver medicaid patients, they absolutely refuse. They have to be delivered by a nurse or midwife. They are trying to set up a midwifery system at the local hospital too, to take care of that problem.

Senator Bellmon. Why does he not see them?

Ms. Henning. They feel like the reimbursement fee is not sufficient.

Dr. Corbett. That is a doctor's double-standard care, that is at the heart of the matter, and you cannot change that with legislative maneuvers. I mean, here we are talking about them taking care of medicare patients if we give them a little more money. I do not see that, that is not the way to go. That does not make any sense.

Ms. Henning. We cannot change the medical system overnight, and I feel something needs to be done to take care of these people.

Senator Bellmon. Well, I do not think that your comments respond to my suggestion, which is that we switch the present arrangement for doctors, health-care related personnel, get paid less where they are needed, and more where they are not needed; I

would like to switch that around.

Only one other question. This present system which seems to make it pretty nearly impossible for the physician assistants to be paidat least in my State we have had some pretty sad experiences with physician assistants, you try to go out in the rural areas and work with doctors, and you cannot get paid. What is that going to do to the physician assistant program, is it too soon to tell? If they have to have a physician looking over their shoulder, do we really need a physician assistant?

Dr. Corbett. It has only been required that they be under the same roof side by side, and in that case the benefits of having a physician assistant is not as great than when you rely on him being

independent. I think we need to remove that restriction.

Senator Bellmon. So, the physician extender program is sort of

under threat, is it not, unless we change the regulation?

Ms. Henning. I think it would have to be changed for the PA, whereas the nurse practitioner can function independently and collaboratively with the doctor because we have our own State license.

Mr. Walston. I think the physician assistant profession is not under threat as such from this hangup, more or less because I know of a specific example where the physician assistant works side by side with the physician; and they are able to see more patients per day on an average day, and it justifies their cost. They have proven themselves to be more effective working side by side with the physician.

But from the rural health aspect their effectiveness does depend upon their utilization not in a physical presence with the physician, but in contact, communication by whatever method.

Senator Bellmon. But this present system means that where there is already a doctor, he is now going to have additional services available because you can also have a physician extender. But in my State there are a great many areas where there are no doctors at all. So, suddenly we cannot have either a doctor, or a physician assistant.

Mr. Chairman, I have no further questions.

Senator Clark. I think we are about 30 minutes behind, and I think we will go on to the next panel.

You have been very, very helpful and have given us a lot of good

information. We thank you very much.

I would like to put a statement in the record from Senator Walter Huddleston of Kentucky, who is also a cosponsor of this legisla-

Next we are going to hear from one of the two State panels. This one is from Iowa. We will hear from Mr. Richard Pustka, physician assistant, Family Practice Clinic, from Madrid; Mrs. Sally Sundberg, also from Madrid, and Mr. Jack Fickel, Red Oak Clinic, Red Oak, Iowa.

While they are coming up I might tell you something about them. Richard Pustka works in a family practice clinic in Madrid, serving about 2,500. He is a graduate of the U.S. Public Health Hospi-

^{*}See p. 119 for the statement of Senator Huddleston.

tal in Long Island, N.Y., in 1973. He is founder and past president

of the Iowa Society of Physician Assistants.

Also on the panel is Sally Sundberg, a resident of the town of Madrid. She has a family there and relies on the family practice clinic. She is active in geriatric care in the Madrid area, and is in

special education in the school system there.

Jack Fickel is a physician in a private medical group, a family practice, in Red Oak. He got his M.D. from the University of Iowa and served as a flight surgeon in the Navy; he operated a single general practice in Red Oak before joining the group association which operates a model medical residency program.

I have had occasion to visit the facilities in both communities. I think what I would like to do is to first hear from Sally Sundberg who is a resident in Madrid and relies on the family practice.

STATEMENT OF SALLY SUNDBERG, MADRID, IOWA

Mrs. Sunderg. Mr. Chairman and members of the committee. I am somewhat out of context in that I am a school teacher here today, but I was released from my duties in Madrid because the community feels very strongly about their health care needs. I am also a wife and mother, and secretary to the board of directors of the Iowa Lutheran Home for the Aging. I am here as a commu-

You no doubt have copies of a more lengthy report which I submitted earlier.* On the front of that report is a picture of our rural community setting, a map. Magnify this town of 2,500 population in the heart of Iowa many times over elsewhere in the State and across the Nation, and you will be getting a visual picture of what

I will be talking about.

I will be discussing briefly the following three areas, the role of a physician assistant to the community and the surrounding area; the role of medicare in the provision of these services; and the

potential effect of legislation along the lines of Senate 708.

First of all, my views on the health care services provided by the physician assistant to the Madrid community and the surrounding area. In order to supplement my views here today I interviewed many of our local citizens. In addition to caring for the ill, the school relies heavily on our physician assistant for decisions in emergency situations. He makes the necessary arrangements with hospitals, specialists, and/or family doctors, depending upon the patient's needs, thereby providing an entry into the health care

Preventive medicine is practiced and taught. The local rescue squad receives continuous health care instructions. Our physician assistant is constantly looking for ways to improve the health of the community in general, and in procurement of emergency equipment. At the time I wrote this, I had no idea our local newspaper would be exploring and explaining the new telemetry system that our physician assistant is trying to establish in the community. This

^{*}See p. 146 for the prepared statement of Mrs. Sundberg.

would be the first in the State of Iowa, and I submit this article to you at this time.*

Senator CLARK. Good.

Mrs. Sundberg. Now to the role of medicare in the provision of health care. Our community has many senior citizens residing in their own homes. Many of these people lack personal transportation to medical services in nearby towns or cities. Madrid also has a retirement nursing home with a resident population of 145. This home has been serving the needs of the elderly in Madrid and the surrounding areas for nearly three-quarters of a century. It was established early in the 1900's. Obviously the home is dependent upon the availability of medical services.

Adjacent to the home is a 22-unit senior citizen low-income housing apartment complex, financed by the Farmers Home Adminis-

tration—Government money.

Just 20 years ago—a mere generation—the Madrid community had two M.D.'s and one D.O. In these past 20 years we have observed the medical services of our community escape from our grasp more or less like sand slipping through our fingers until 5 years ago, when we found ourselves without local medical services; and

this caused a crisis in our health care at Madrid.

We now have a satellite family practice clinic, supervised by Boone, Iowa, physicians and staffed by a physician assistant. The incongruity of the present situation is that stringent limitations are placed on physician assistants' skills, to people supported on welfare programs—specifically medicare—in spite of the fact that a Federal education program pays all tuition and expenses for students training to become physician assistants.

dents training to become physician assistants.

Now, why is it that physician assistants can provide broad medical services to private-pay—those of us under 65 and not on ADC, or some other welfare program—yet their skills are not good enough to serve independently those on welfare? Which brings me

to point No. 3,

Potential effects of legislation along the lines of S. 708. If legislation is not enacted to allow physician assistants to serve with reimbursement to the over-65 population, medical services to large segments of rural America—and more specifically to Madrid—will

be nonexistent.

According to the sponsoring physicians through the satellite family practice clinic in Madrid, health care will not be provided to this community unless existing legislation is changed. It therefore seems logical to keep up with today's needs. S. 708 should be approved, thus providing for the extension of skilled medical services in keeping with the moral intent of citizen welfare, and thereby removing the roadblocks that presently exist in transporting our medical expertise from the urban centers to the rural population.

In short, Madrid does not have an M.D. and will not have one for some time. Madrid is pleased to have the services of a physician assistant. The problem is, Federal regulations say the physician

^{*}See p. 150 for the article submitted to Mrs. Sundberg.

assistant cannot be paid with medicare funds for the over-65 population. It appears one program of the Government is supporting expansion of medical services in rural areas, and another program is limiting the services. An appropriate change in legislation could solve this problem.

Thank you very much for this opportunity to speak on behalf of

rural Iowa.

Senator Clark. Thank you very much, you summarized it very

well, especially at the end.

We are going to hear now from Mr. Pustka. As I said earlier, I have been in the clinic in Madrid, have seen the facility, and talked with the physicians in Boone who work with you.

So, we are very pleased to have you here, and you may proceed in

any way you choose.

STATEMENT OF RICHARD PUSTKA, PHYSICIAN ASSISTANT, FAMILY PRACTICE CLINIC, MADRID, IOWA

Mr. Pustka. Thank you.

I have been sitting here, listening to the testimony this morning, and they have been talking about myself, my friends and my neighbors when they talk about the delivery of rural health care, you know, what the doctors and myself in Madrid are all about.

I am going to fall back, with respect to your time, on my written

testimony which, I understand, is part of the record.*

I am sorry to see that Senator Dole had to leave, I wanted to let him know that this spring the sunflowers are flourishing well, not as a weed, in the State of Iowa.

Senator CLARK. That is right.

Mr. Pustka. I wanted to share some thoughts that I have with you, with the understanding that these thoughts are from my perspective as a physician's assistant, living in rural America, which

is all around us.

A couple of things. Without legislation like this, or very close similar wording I feel that most PA's, or nurse practitioners, in clinics in rural areas where the practitioners are geographically independent and remain so, are not going to be around. I do not think the Social Security Administration is an even temporary answer. Our practice became part of this study on January 3 of this year. We have to hire new help, a full-time employee, just to run the paperwork. Because we are part of the study we have accepted an assignment which has been, again, the old-time inadequacy of payability to the rural area and to the rural physician, just getting 10 or 15 percent less than an urban physician; and many times as high as 40 or 45 percent more dollars are received from either private or governmentally sponsored insurance programs for the same procedures. I think that problem has to be addressed, and maybe it can be through this bill.

I would like to avail myself to you at this time for any questions

you may have, after we have heard from Dr. Fickel.

Senator Clark. Thank you very much. Dr. Fickel, go right ahead, and then we will have some questions.

^{*}See p. 151 for the prepared statement of Mr. Pustka.

STATEMENT OF JACK D. FICKEL, M.D., RED OAK CLINIC, RED OAK, IOWA

Dr. Fickel. Mr. Chairman, I present this testimony as a physician engaged in private practice in rural southwest Iowa. I was in solo practice there from 1953 to 1975, at which time another physician and I formed a private group practice. We were joined by three, young, board-certified, family physicians. Our group established a satellite office in Malvern, Iowa, which has a population of 1,158, 20 miles from our clinic in Red Oak, which has a population of 6,210. The satellite clinic is staffed full time by a physician assistant and by one of our physicians 3 half-days per week. In the central clinic, we employ a family nurse practitioner.

Our program has been designated a model regional primary care program by the University of Iowa. This designation has not altered our private practice status. We have received planning, consultation, and educational assistance from the College of Medicine and through them have received financial assistance from a Kellog Foundation grant. And I should say that the viability of our Malvern satellite is dependent upon receiving the generosity of the Kellog grant, otherwise we could not keep it open under

present reimbursement.

Our family nurse practitioner provides patient services both in areas of acute care and preventive medicine. She conducts prenatal classes, nutritional counseling, family counseling, patient education, well-baby exams, physical exams, as well as treating designated illnesses by prescribed protocols. She makes home visits and assists in community health programs. Her full utilization in nursing home and hospital inpatient and outpatient care is limited by the restrictive policies of remuneration in the existing medicare legislation.

The physician assistant in our satellite performs functions similar to those of the nurse practitioner. Malvern had three doctors until a few years ago. Now they have but one who is elderly, practices less than full time, and is often absent from the community.

There is a nursing home in Malvern. Those patients previously had to rely on occasional visits by doctors from other towns. Our physician assistant is immediately available in the community for emergency cases and provides a valuable role in health education and preventive medicine in the schools and the community as a whole. He has 24-hour contact with the clinic physicians by phone and, in addition, a physician's presence in the satellite office for one-half day on Monday, Wednesday, and Friday. On Saturday mornings, he returns to the clinic office in Red Oak for clinical and educational experience with all four physicians. Continuing medical education in our community, as well as in approved programs throughout the United States, is a vital part of the role of the family nurse practitioner, the physician assistant, and each physician in our medical group.

Some 30 percent of the residents of our service area are over the age of 65. Therefore, statutory and regulatory restrictions on reimbursement for physician and physician extender services by medicare are of vital importance to our medical program. The fact that many of the services provided by the family nurse practitioner and the physician assistant are currently nonreimbursable makes a financial hardship for our practice. Perhaps of more importance is the denial of other valuable services these well-trained practitioners could provide to elderly patients if reimbursement were allowed.

The use of physician extenders in rural practice is relatively new. Patient acceptance is sometimes slow in coming. Knowledge that Federal programs will allow payment for the extender's services only if the physician is physically present to supervise the extender detracts from that acceptance. Indeed, it implies that the extender is not qualified to act in the capacity for which he or she has been trained and certified.

It is a ridiculous contradiction that some Federal programs would seem to wholeheartedly support the physician extender concept, while other regulations condemn their work as unworthy of remuneration. Your efforts to correct this unfortunate situation is

salutary.

I hope that the legislation will make possible reimbursement for physician extender services in rural settings. Since the law in many States, including Iowa, requires certification of each extender as an employee of and directly responsible to a specific physician licensed in that State, provision for reimbursement to that physician for the extender's services is desirable. The Iowa medical licensure law makes it impossible for any entity, except a licensed physician, to practice medicine in the State. Care must be taken to provide wording in this legislation which does not prohibit the reimbursability of the services of an extender who is an employee of a physician.

The provision for regular review by physicians of all medical services furnished by physician extenders is well taken. In Iowa we consider onsite review by the physician no less than biweekly to be desirable for quality assurance. Our licensing law requires

biweekly visitation.

The provision for the development of treatment and examination protocols jointly by the physician and the extender is also to be commended. Availability of physicians for consultation, maintenance of good clinical records, and provision for availability of

hospital admission are all necessary for adequate care.

Appropriate procedures for utilization and quality of care review are increasingly important in medical practice. Techniques of quality assessment in ambulatory care settings are improving. I am proud that the American Academy of Family Practice has been in the forefront of the development of quality assessment and peer review.

Adequate definition of the term "physician extender" is difficult. I believe that for the purposes of this legislation the definition in

S. 708 is well done.

Again, I would like to commend this subcommittee's efforts to improve the availability of quality medical care for rural Americans. It is my earnest hope that the Federal Government and the private sector of medical practice in this country can end their adversary roles and join together in a genuine effort to alleviate

the plight of millions of Americans who must depend on both to answer their medical needs.

I will be happy to attempt to answer any questions which you

may have.

Senator Clark. Thank you very much also, Dr. Fickel. You worked for many, many years, not only in solo practice, but also in putting together a group of doctors to serve rural areas. We visited the Malvern satellite as well, as you know. I know the outstanding job you have done in that part of the State working with the University of Iowa Medical School.

I think I would like to first ask Sally Sundberg a couple of questions because you are one of the users of this facility in Madrid.

Are you completely satisfied with that clinic? Do you feel that without having a physician there all the time in the building is a problem? Do you have any reluctance about that?

Mrs. Sunderge. Well, initially I did have. I had considerable reluctance about going to someone who was not as well trained for

medical problems.

However, after seeing him on the job and in the community, I was very much sold on the fact that we needed his skills and expertise. At this time our Boone physicians—Boone is 15 miles away, the county seat town—will not take any new patients. As a result local people can call on the physician assistant and have an en-

trance into the medical service area.

My family, as well as myself, have used our physician in emergency situations. When you need someone in a hurry, you need someone locally. In interviewing a large cross-section of the community, I have yet to encounter any one person who has been opposed to his services in the community—and I did not expect to find this. I thought there might be—usually there is—a little bit of dissatisfaction.

We have a new administrator in our home who serves on the

National Advisory—

Senator Clark. That is the Lutheran home?

Mrs. Sundberg. Yes; the nursing home. We have a new gentleman who came to us from Minneapolis, who serves on the National Advisory Board of the American Association of Homes for the Aging. He indicated the same kind of response in his getting acquainted in the community. There is complete satisfaction with the role of our physician assistant in the community.

Also, we do not see our physician assistant standing in the way of attracting an M.D. to the community. He is supporting that kind of an effort, and of course that is our long-term goal. We would still like to have an M.D. in the community, but that would not preclude anything which our physicians assistant does, or take away, or detract from; it would only expand the quality of care.

Senator Clark. Now, you work with particular emphasis on problems of the elderly, their health problems, and so forth. To what degree is the elderly community served in that respect by having a physician assistant? Is that pretty helpful to you?

Mrs. Sunderg. We have approximately \$1 million facility there, in our health care to the senior citizens in the home. Without this kind of emergency service, 24-hour service, we would be losing

occupants. A home with 145 beds requires a certain amount of staffing, and so forth. If occupancy drops it becomes less than a financial success operating in the red due to the lower occupancy. Financially it would be only a short time and we would find ourselves having to close our doors and close the facility. Obviously these patients or residents would have to be moved elsewhere, and chances are they would be moved to the city. Moving them to the city further crowds the city conditions, and we would be supporting new facilities in the cities for housing for the elderly.

Senator Clark. Now, Mr. Pustka, what are the State policies in Iowa relating to services provided by physician assistants; does the Iowa medicaid, for example, provide reimbursement for your

services?

Mr. Pustka. No.

Senator Clark. They do not.

Mr. Pustka. They do not. They have in the past shown strong tendencies to support the idea of utilization of physician extenders in Iowa, but there has been no active attempt either to go toward or against the concept. They might be looking the other way. We are talking about upward of 52 physician assistants in the State of Iowa, and upward of 3,500 people, just within our State in rural areas are losing their entry to health care systems; it has been

fantastic over the years in Iowa.

I would like to let Senator Allen know—I hope he will review the testimony later—there are quite a few farm boys in Iowa going to the University of Iowa medical program, and returning through the family practice residency program, and the other programs set up by the university, to rural areas in a positive way. Not in short-time positions, but in different programs to try to get physicians into the rural areas. I think that has been an insult to many of the people in rural towns.

Senator Clark. What is the cost per visit for a patient which you serve in a clinic? Do you have any statistics on what the average cost would be? Or have you never had any reason to see that?

Mr. Pustka. I have never had any reason to look up the average cost for a patient on a statistical basis. There are general figures that I could share with you, that might give you some insight.

Satellite offices, historically, have never been moneymakers, whether they are staffed by a physician extender or a physician on whatever part-time basis. After 3 years' time the clinic that I am part of was within \$2,000 of being solvent, after expenses. The doctors were quite happy with this; they are personally subsidizing this health care for the thousands of inhabitants of the town of Madrid, which is located in a geographical location where you cannot have a physician.

Senator CLARK. Could you conceive of a situation in which it

could finance itself?

Mr. Pustka. I think on the reimbursement for the actual cost of the clinic, no such clinic, as you have suggested yourself, could maintain solvency financially for a rural clinic; I really strongly believe that.

Senator Clark. Now, how many patients do you see on an average day? Do you have any idea?

Mr. Pustka. On any given day 25 to 35 people.

Senator Clark. Do you have any idea how many of those might

fall in the medicare category, be medicare enrollees?

Mr. Pustka. Yes; I audited my charts before I came. Of 2,200 active persons 34 percent are 65 and over, and eligible for title

Senator Clark. So, one-third.

Mr. Pustka. Yes.

Senator Clark. One out of every three.

Mr. Pustka. So, you can see I am trying to express a little urgency. Again, unless this bill or very similar-worded legislation is passed in a very short period of time not just my clinic, but other clinics which I have had occasion to visit, are not going to be there. In other words, what you are talking about, health care is not going to be available.

Senator Clark. Can you tell us very briefly what your own train-

ing and education was for this position?

Mr. Pustka. Without revealing all my hidden credentials-

[Laughter.]

Mr. Pustka. I served as a medical corpsman in the U.S. Navy for 4 years and received different medical training through the Armed Forces, especially through the Navy. I served as an independent duty corpsman for the last 2 years of the 4-year tour. I did work in hospitals for several years after that; did successfully graduate from the physician assistant program in Staten Island, N.Y., a public health hospital.

Senator Clark. Now, do you diagnose, treat, prescribe—all

three?

Mr. Pustka. Yes; the answer is just, yes, under the guidelines that are set up within our practice, and under the supervision of Dr. Anderson and Dr. Rouse. Diagnosis, treatment, and prescription within certain guidelines.

Senator Clark. I remember from our discussions in Iowa that you are constantly in touch with your physicians in Boone. I think I can say from your telephone bill how often you call there.

Mr. Pustka. Considering it is only 14 miles away a \$250 bill has been a very high expense, on a monthly basis, for the office. We are lucky in that our county hospital—for Senator Allen's benefit-most of, not all of the county hospitals in Iowa, and the firehouse, are connected through the University of Iowa's hospital system.

I hate to take too much of your time.

Senator Clark. Now; let me ask you, do you make house calls and

go to the nursing home?

Mr. Pustka. I visit the nursing home on a clinic round weekly. This last 3-month period—in again auditing our charts—I have made an average of 36 house calls, after-hour calls within a month, which is a little more than one a day. And I might add that besides our telephone communication with the physician, and besides whatever prearranged guidelines or supervision we have, criteria for diagnosing, treatment, and prescription, we do have a radio system also that is rather sophisticated and has been very helpful when talking to the coronary care unit, not just for myself, but the

fire department.

Senator Clark. Dr. Fickel, you were in solo practice. What are the disadvantages for a young doctor to be in solo practice? Why do they not like to do it? You eventually switched to a group practice. Why so?

Dr. Fickel. I wish I had done it many years sooner. The primary disadvantage of a solo practice is professional isolation, a lack of peer consultation that goes on constantly among the doctors in the group. One of the obvious disadvantages is the feeling of being on call 24 hours a day, 7 days a week, 365 days a year; or leaving your practice unattended, and your patients isolated.

It provides more time for continued education studies, both in your hometown by bringing in outside programs, as well as attending programs throughout the country. You have more time with your family. You can provide a better service to the patients on the hardware that is available, which is very expensive and very inefficient.

For the four of us to practice now separately, we would have to duplicate not only personnel, but also a lot of expensive hardware to provide the service to patients individually. We also are located next-door to the county hospital, so that we can give further savings to the patients by utilizing their sophisticated laboratory equipment.

Senator Clark. So, you really have the same kind of practice, consultation, the same kinds of advantages that one would have in a large city, let us say. You have the facilities, you have the equip-

ment, and you have the personal consultation.

Dr. Fickel. Yes.

Senator Clark. And you give first-class medical care.

Dr. Fickel. Fundamentally it has improved the level of medical care, and I have improved my quality of life. It is less remunerative in monetary terms, but fortunately I have attained an age when I realize that there are other things more valuable than that.

Senator Clark. In your judgment, would it be desirable to have a minimum of two physicians practicing together in rural areas?

Dr. Fickel. I have done a great deal of study, and the University of Iowa has done a great deal of study on what attracts doctors to rural settings; and in polling recent graduates and also polling those in residency training, and those in medical schools, it is a necessity to have the group practice for the recruitment of almost all the doctors coming out of medical school and coming out of residency programs. They want three to four in groups, preferably. It maximizes the advantages I mentioned before, of the peer review, educational programs, and greater efficiency.

If I may, Senator, this however increases the problem which has been alluded to, about the availability of physicians in smaller towns because a population area for a group of three or four physicians, obviously it is not going to be a town of 1,000 or 1,500, it has to be a reasonable population center. Probably, in Iowa at least, with our concentration of the farm areas, we are talking about towns of about 4,000 to 6,000, to 8,000 where the physicians would be located. And our experimental model is to provide satellite

services at a distance of about 20 miles, staffed by physician extenders.

Senator Clark. Good.

Dr. Fickel. This is simply a model, it is not the only way to solve the health-care problem for the rural areas, to underserved areas. I think that gets back to the concern about separate programs between the urban and the rural setting. I am not sure that a satellite-type operation in a city is a very practical thing; and I am sure it is a terrible temptation for over-utilization—I hate to use the word "fraud"-but over-utilization of the availability of large amounts of money because of large amounts of people. Out in the country you are never going to make a fortune in these areas of satellites, they are not very efficient; there just are not that many people.

Senator Clark. Senator Leahy?

Senator Leahy. Is it not safe to say, if you compare the two, the question of population density is going to be totally different, the question of transportation is going to be totally different, and these are the most important reasons for some kind of a specialized rural health care delivery system. Is that a fair statement?

Dr. Fickel. I think it is an excellent statement. As a rural soul I would like to make the analogy of trying to fit the harness of a draft horse on a race horse. You have different problems. I also suspect the race horse would be in town, that is where most of the bets are made, and that is where the money would go.

Senator Clark. That is what you were saying earlier.

Senator Leahy. That is what I am saying, and I cannot emphasize it enough. Whether it is the housing program, the poverty program, or anything else, we see precisely the same thing: One or the other loses; and usually the rural area loses.

Senator Clark. It always seems to be easier to deliver where people are crowded together. More money is spent on the delivery

process in more sparsely settled areas.

Just one last question, Dr. Fickel. I have the impression that a number of physicians have real doubt about the idea of physician extenders. Now, you have worked with physician assistants, nurse practitioners, and other physician extenders. What is your own judgment about why that is the case? What is your own experience

Dr. Fickel. First of all, in dealing with physicians, you are dealing with tradition-bound individuals who have a very difficult time changing systems. We adapt, I think, rather well to new medication, to new techniques of treatment, but in techniques of delivering health care we are certainly traditional. Our egos rather by the nature of what we do, rather than any defects in our personality, maybe they recruit us wrong. But many physicians, established physicians particularly, feel this is a threat to themselves because it perhaps damages their own ego, feeling, that someone with as little training as a physician assistant has, can do tasks which they have held to themselves as physicians.

Now, I do not think they feel it is a threat monetarily. They do, many of them do honestly feel it is a threat to quality care. This is a matter of misunderstanding because—now to address the second part of your question, there is just no reason in the world for anyone to go to school for a period of 10 to 15 years, including the residency training and post-high school education, to examine a well baby, for example, measure the baby's head; or to treat a sore throat, or take a throat culture. And many physicians in this country are wasting the physician manpower by taking on those particular tasks themselves, or delegating them to the nurses, with which they feel very comfortable.

But under proper protocol with well-trained, certified extenders—whether they be nurse practitioners or physician assistants—they are no less than doctors, they are just as qualified as the physician to perform those roles. It is important that they not get out of the area of their expertise. But within the areas that they are trained for they do the jobs as well as doctors, and in some cases, by doing

them more frequently, are doing them better.

Senator Clark. That was an excellent statement, we appreciate it. Mr. Pustka. I would like to support that statement, and I would like to make mention of a recent article in the Journal of the American Medical Association dated November 29, 1976, which I attached to the testimony we gave you.* It faces this specific question on the quality of care and the outcome for the patient. And as was testified this morning by another individual, there is methodology available that has been utilized to show that the care rendered by physician assistants, given the qualifications expressed by Dr. Fickel, is very comparable, statistically, to the care given by the physician. I think that is a big point and gives some insight into the hostility that some groups of people have.

Dr. Fickel. Senator, interestingly enough, organized medicine has been more supportive of the program than individual doctors themselves—and this is not always the case in health care delivery. But the American Medical Association, the American Academy of Family Practice, Pediatrics, and other organized groups do support

this concept

Senator Clark. Senator Leahy?

Senator Leahy. I really have nothing to add, Mr. Chairman. I was extremely impressed with the testimony that you received in Iowa last year, and I am impressed by the testimony submitted by this panel. I think you are fortunate to have in your State people of this caliber. And I think the people in Iowa, as so many rural States, face the same kind of rural problem that we have in Vermont. Mr. Chairman, they are fortunate having you represent them.

Senator Clark. Thank you very much, we appreciate very much

your coming.

We are going to hear next from the Vermont panel. As I said earlier, Senator Leahy organized the first hearings on this subject and really discovered—for this committee at any rate—the nature of the problem of medicare reimbursement for these clinics. He has really been a moving force behind this legislation.

The committee is pleased to have people here from Vermont. Senator Leahy, as a matter of fact, is going to chair the remainder

^{*}The article referred to by Mr. Pustka is retained in committee files.

of the panels, the Vermont panel, the special topics panel, and the professional groups panel.

So, we particularly welcome you here from Vermont, and look

forward to hearing from you.

Can you introduce the panel? We are switching chairs.

Senator Leahy [presiding]. Before switching chairs, if anybody wants to stand up and stretch a little bit, please do.

[Whereup a short recess was taken.]

Senator Leahy. We will reconvene the hearings. We are going to try to keep the time to 5 minutes for each witness. I would emphasize that statements will be placed in the record in their entirety. I would much prefer if you would just give a general summary of the points, if there is any one point you want us to remember, make

that point; and then we want to go into questions.

The Vermonters that will testify on this panel will be Betsy Davis, the executive director of the Visiting Nurse Association of Burlington, Vt.; Sue Heath, a nurse practitioner at the Champlain Island Health Center, Grand Isle, Vt., both of them are well known in Vermont and well known to me through the work that they have done for years. Dr. Henry Tufo, of Given Health Care Center, of Burlington, Vt., who provides physician backup for the Grand Isle Health Clinic. Dr. Tufo has also been extremely helpful to me and my office in what we have done, developing the legislation to date.

Dr. David A. Hantman and Linda Labroke, who is a nurse practitioner from Danville, Vt. They are the principals in the Danville Clinic. Linda Labroke is a nurse practitioner there, and Dr. Hantman provides the backup and auditing of the office. The clinic just opened last week, so there has not been too much experience in that week's time, although a week in the winter time is enough experience for anybody, in Vermont. I think it will be interesting to the committee to hear about the support they have received from the community.

So, we will start the panel with Betsy Davis, the executive di-

rector of the Visiting Nurse Association.

STATEMENT OF BETSY DAVIS, EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION, BURLINGTON, VT.

Ms. Davis. Thank you, Senator Leahy. The written testimony, which I have submitted for the record, describes the economics, the mortality statistics, and the geographic isolation of Grand Isle County; and the data is probably typical of that of many rural areas in the country. So, I will not repeat these unless so requested.*

I also wish to make reference to the documentation in that written testimony of the fragmented, irregular pattern of health care in Grand Isle prior to the inception of the health center and, in addition, the inconsistent availability of physicians that have prac-

ticed historically in Grand Isle County.

Our major goal in starting the health center was to provide a coordinated, integrated system of health care, which would be available, accessible, and accountable to the people of Grand Isle County. The important features of the health center are:

One: Consumer involvement and governing responsibilities.

^{*}See p. 154 for the prepared statement of Ms. Davis.

Two: Utilization of nurse practitioners as primary caregivers with backup physician availability through telephone consultation and periodic onsite visits.

Three: The linkages to the rest of the health care system.

Four: That it is cost effective.

Five: That services focus on prevention and health education, as well as other phases of primary care; and

Six: That it is accountable and there is a system of audit in which

all providers practicing there in that system must participate.

Sue Heath, nurse practitioner, will respond to those items that describe the services and system of care, and I would like to elabo-

rate on a few of the other items.

The Grand Isle County Health Council has been an active partner in the inception and evaluation of services at the health center. In addition, a consumer advisory group has been created which makes recommendations for additional services, and provides a feedback mechanism for patient concerns. We support this local responsibility, believing the providers must be responsible to the people they are trying to serve; it is for that reason we believe that a certain defined level of health care must be community based and located where people live. We do believe that transporting people 30 to 60 miles to health services for which they have no responsibility is basically self-defeating.

We ultimately believe that this increased responsibility, involvement, and knowledge will be a large factor in helping to create a system of health care that is financially sound, humane, and re-

sponsive to peoples' problems.

The community acceptance of the nurse practitioner concept as an extension of the health care system, providing an entry point to total care has been well documented. I make reference to the rural health hearings that were held by Senators Clark and Leahy in Vermont in February 1976. The evening session of those hearings was held in Grand Isle County, and a large number of consumers testified to the importance of the center.

Almost 800 people of a population base of slightly over 3,000 made 2,200 visits to the health center in its first year of operation when it was open 4 or 5½ days per week. The second year showed a 34-percent growth; in the first 6 months of this current fiscal year

showed a growth of 33 percent.

The major point I would like to make is that while a nurse practitioner is working in physical isolation, she is part of a larger

support system. It is our task:

First: To define those primary care services that can be provided onsite in Grand Isle County, considering the population base, the population problems, and economics of the area; we do not intend to have a full primary care center located in that location.

Second: To provide a consistent and reliable service onsite, and

guide the patient through the rest of the health care system.

The financial viability of the health center is a major concern. We spent the first 2½ years piecing together various grant programs and fee-for-service income in maintaining the center. We were awarded a rural health initiative grant in July 1976, giving

us once more some additional time to further develop the system and work toward improved reimbursement.

We realize that grants cannot be a long-term solution, and that the health center must fit in with the prevailing methods of re-

imbursement.

It has become painfully clear that third-party reimbursement of nurse practitioner services, when a doctor of medicine is not onsite, is a critical issue to the continuation of the center. If the problem of third-party reimbursement cannot be solved, then the nurse practitioner in the rural system is not viable. Yet, we feel we have been able to provide a quality service that is acceptable, accessible, accountable, and cost effective. I might mention that our average cost of service in the first year was \$11.55, and \$12.50 for the second year, and that is including all screening and laboratory tests in those costs.

Senator Leahy. As compared to what the cost would be for the

average visit of similar nature to the medical center.

Ms. Davis. That is difficult to respond to because there are addon expenses for laboratory. A basic office visit runs between \$10 and \$15, and then the laboratory expenses are an add on. And then there are additional savings for people by not having to transport

themselves to distant places.

I would like to mention an innovative step taken by Blue Cross/Blue Shield in addressing the reimbursement of services, when they entered into a contract with us in September 1976. This contract is further described in my testimony. But the important components of this contract are that it reimburses a system, and not the individual practitioner for services provided.

Second: That it requires a system of care that is accountable, and has a mechanism for ongoing audit of practice of all the providers

of care.

And, third: That it reimburses on the basis of actual cost fol-

lowing audit.

Senator Leahy. I will say this for the record, Blue Cross and Blue Shield certainly received praise from me and others on the floor of the Senate.

Ms. Davis. Currently, 10.9 percent of the population in Grand Isle County is over 65 and approximately 180 people, or 44 percent of that population, have been seen at the health center over the past 2 years. If there was reimbursement for the services provided for that population, we believe that this would represent approximately 20 percent of all services provided. This would be one more very important step to improve the financial viability of the center.

Passage of S. 708 would remove a significant barrier in supporting the concept of rural health centers and the system I have attempted to describe. We believe that nurse practitioners and physician assistants as part of a team provide an appropriate entry point in a total system of care and assist in creating the necessary linkages to that system. We believe that this concept could be critical in helping to create order out of the chaos of the present nonsystem. And finally, we are convinced that improved accessibility combined with education and consumer responsibility leads to earlier intervention in illness, improved preventive practices and ultimately reduced costs of total care.

The passage of S. 708 would be significant for both its financial implications for rural health centers, and for support for a system of care. Thank you for this opportunity.

Senator Leahy. Thank you very much. Before we go to the ques-

tions we will go through the whole panel.

STATEMENT OF SUE HEATH, NURSE PRACTITIONER, CHAMPLAIN ISLAND HEALTH CENTER, GRAND ISLE, VT.

Ms. Heath. The testimony of Elizabeth Davis has described some of the broad objectives of the health center; I will give a descrip-

tion of services and system of care.

The Champlain Island Health Center and services of the nurse practitioner provide an entry point in the total system of primary care. The services are evaluated by a team of health care professionals, with the nurse assuming the major onsite responsibility.

We designed the service delivery having four phases of action; the first is the defining and collecting of the data base; second, developing a problem list; third is developing and implementing a plan of care, and fourth is following up on the results of the plan.

I want to briefly discuss the nurse practitioner's responsibility in relation to each. The initial process is to examine the demographic, economic, and mortality data of the population, and establish a data base identifying those problems which should not be missed for this particular population. Having defined what we want to identify, we then define the data needed to insure precise identification, assessment and management of any problems that we identified on our data base. Defining a data base is shared responsibility between the nurse practitioner, physician, and any other consulting staff, such as psychiatric social workers. The actual data collection is done by paramedic nurse or physician, but the nurse assumes primary responsibility for completion. Each piece of data has a defined end point which may be a positive on a questionnaire, or an abnormal physical-physiological finding. Again, the end point is established generally by the nurse and physician after researching the latest literature. They are applicable to all patients; they provide a consistent approach to a defined problem. The end point signals a problem that necessitates formulation of the problem list. As indicated, the nurse and physician have shared responsibility in data base identification and collection, and continue to share responsibility in problem formulation. This occurs even though the physician is not present.

Once a problem is identified the system requires development of

a plan of care which includes:

One: Further evaluation;

Second: Patient management, and

Third: Patient education.

For example, the action may be to refer to the M.D. for further plan development. If the plan is to refer, then the nurse is facilitated, after a complete data collection, to insure the most effective use of the physician's time and skills. These deferred actions are commonly referred to as protocol, and that is usually developed by the physician and nurse practitioner.

The division of the plan into three action components, which I previously identified, in addition with the use of the goal, enables further evaluation of intervention. This precision is documentation demanded by the system, coupled with the protocol, facilitates more effective protocol of the care provided. The nurse practitioner is the primary care provider and can pinpoint if and where the intervention has failed. The controls and discipline in the structure of the POR provide an audit trail, and is a means to evaluate the performance of the provider and the quality of the care provided.

Audit reinforces and evaluates adherence to the system, and insures accountability to meet our goal of effective and efficient care. It enables us to examine the effectiveness of the system for individual patients, as well as efficiency for a group of patients. There is a constant feedback for alteration and data collection for management that is considered appropriate. The precise definition of the data base enables the clerical persons to audit the reliability of the data collection. Presently 60 percent of our records are audited for these behaviors. In addition, records are submitted to the physician, nursing supervisor and a psychiatric social worker for audit of analytical sense and reliability of our data collection. At such time that our rules are shown to be inefficient or ineffective, we can then redefine them.

A final and important issue is that of patient responsibility in managing their problems. The patient has an opportunity to audit their own records and are given a copy of it. Use of protocol provides a consistent approach to a problem, providing a patient a source of

reference in dealing with future similar problems.

Senator Leahy. We noticed in our hearing in Vermont that patients have their own records, and they have a chance to go over them. I would like to bring out the fact that this is not done in many, many places. Having done this now for 3 years, what is your attitude toward its success?

Ms. Heath. The consumer sees that in very positive terms. Also, it provides them the opportunity to look over the data reflected—

it really enforces what you are providing.

The Champlain Island health center supports a system which utilizes the skills of many health care providers. We have attempted to establish provider and patient responsibility, so that the center operates efficiently and effectively. We recognize that Grand Isle County has many unmet health needs, but with limited resources we had to maximize. We had to develop services that were consistent, to meet the direct needs of the patients. The system is for the nurse practitioner to focus on the patient's social, environmental and cultural factors as they impact on his mental health. We gear each visit toward patient education in helping the patient to understand how to maintain balance.

Senator Leahy. And that, again, led to them having their own

records.

Ms. Heath. Yes, that reinforces patient responsibility.

Senator Leahy. I will put the rest of your statement in the record only because of the time problem we have, as all members of the panel will have a chance to testify. Your statement will be put in the record, in conjunction with your testimony. Dr. Hantman.

STATEMENT OF DAVID A. HANTMAN, M.D., DANVILLE HEALTH CENTER, ACCOMPANIED BY LINDA LABROKE, NURSE PRACTITIONER, DANVILLE, VT.

Dr. Hantman. Most of my testimony is redundant now in view of the number of witnesses we have had today, who have given many of the same points.*

I would like to spend a minute or two just describing the Danville Health Center which opened up a week ago, as you pointed out, run

by Ms. Labroke and myself.

Danville is a rural community, certainly isolated, in northeastern Vermont, with a population we serve of 3,000 people. It is an impoverished community with a high unemployment rate, very low per capita and per family income, and a high number of people on

welfare programs of various types.

There was really no medical care available in Danville for the last 5 years; the one general practitioner retired approximately 5 years ago. The nearest physician in St. Johnsbury is 10 miles away. Ten miles does not seem like much of a distance, but in the winter in severe Vermont weather it is very difficult to get over the mountains between Danville and St. Johnsbury; this is an almost impassable barrier, as many people in Danville know, and surrounding communities.

The center is staffed by Ms. Labroke and supporting personnel, and supervision is provided by myself and my partner in St. Johnsbury. The center is open 40 hours a week during which time patients are seen by appointment by the nurse practitioner. My partner and I will be in attendance at the center a half day per week for complicated medical problems, and in addition we perform daily audits of the patients' charts. Physician supervision is further provided by telephone consultation with the nurse practitioner, by referral of complicated or severely ill patients for office consultation or hospitalization, and by routine audit of all patient records. Most important, treatment protocols dealing with specific medical problems, written by the physician, are used by the nurse practitioner in managing the patients.

The center was established in very close consultation and very close cooperation with the people of Danville and their elected representatives; they have been working with us for the past year to establish the center. The center is located in the town hall, which

has been remodeled by the town.

Senator Leahy. Could such a center exist without community

support?

Dr. Hantman. Well, it could exist in a place other than the town hall, but I do not think there would be any way to exist with-

out community support.

We have a volunteer network of townspeople who have volunteered their time to drive elderly citizens to the center, to St. Johnsbury to the X-ray department and other services; and also to pick up drugs which we may not stock in the clinic in St. Johnsbury and bring them back to the patients.

^{*}See p. 157 for the prepared statement of Dr. Hantman.

A 14-member board of directors represents various aspects of the community and is responsible for the establishment and operation of the center. It is organized as a nonprofit corporation.

The center operates on a fee-for-service basis with fees set at a lower level than prevailing physician's fees in the area. In addition we received a 2-year grant from the Kellogg Foundation to cover some of the startup costs, and for partial expenses and operating costs for the first 2 years. This is a diminishing grant with a higher amount of money the first year, a lower amount the second year, and then cuts off completely in the third year. We expect it to be totally self-supporting by the end of the second year.

In addition a pilot reimbursement program was begun at our suggestion by the Vermont-New Hampshire Blue Cross/Blue Shield

to reimburse for nurse practitioner services.

We offer comprehensive health care, and this is including treatment of acute and chronic medical problems, preventive medicine and health maintenance services, complete initial examinations. This is documented and submitted in the testimony.

We estimate that at least 25 percent of our patients' visits to the

center will potentially be covered by medicare.

We strongly believe that the inclusion of physician extender services under medicare will benefit our patients in two ways, by increasing the accessibility of health care and by reducing health care costs. Now, the accessibility of health care has been previously documented in testimony, and I will not get into that now other than to say, in addition to what you have heard from the other witnesses, that if medicare does not approve nurse practitioner services, it will be very hard for us at the end of the 2 years of the grant program, and we will probably have to close up shop.

Reduction of health care costs, I think, is important, and I do not think this has been testified to, or dealt with at any length by

previous witnesses, so, maybe I can go into this.

We feel that our center, incorporating the classical concepts of physician extender use—it is a model clinic in many ways—can effect substantial savings to the patients and to the medicare program itself. As outlined in the two tables which you have, these tables compare costs in the Danville Health Center with costs in nearby physicians' offices, and also with costs in the local hospital emergency room for treatment. I picked out two specific acute illnesses to calculate the cost per illness—not the cost per visit, but the cost per illness—comparing visits to the Danville Center, to a doctor's office and the hospital emergency room.

For acute upper respiratory infection—with strep throat—the Danville Center will charge \$8 for an office visit; \$3 for a throat culture, and \$2 for a 10-day supply of penicillin. Remember, back in the movie you saw the reimbursement under medicare alone to the clinic in Washington is \$25 for a visit, I believe, and this is a total of \$13. In the physician's office in St. Johnsbury the total would be \$16.25. So, right there you see savings of \$3.25 per visit,

or a 20-percent savings, just for one illness.

If a patient went to the emergency room, the total cost would be \$32.85, and we feel we save the patient \$19.85, or 10 percent.

Medicare, which pays approximately 80 percent of most of the expense, would similarly save. Medicare itself would save 15 percent per physician's office visit, 63 percent on emergency room service;

and the patient or his insurance would have similar savings.

For minor lacerations—cuts—not requiring suturing, in which the procedures are an office visit and tetanus toxoid, the savings realized by the patient coming to the Danville Center are 23 percent over an office visit in St. Johnsbury, and 66 percent, or a grand total of \$20 savings for this minor procedure over an emergency room visit in St. Johnsbury. The savings to the medicare program would be 24 percent over an office visit, and 66 percent over an emergency room visit. We can extrapolate those costs to other illnesses also, and it would work to about the same percentage of savings.

So, we feel that we can save the patient money, and can as well

save medicare money.

So, we at the clinic feel that passage of S. 708 would be beneficial in helping us increase the availability of medical care to the elderly population of our area, and it would reduce the cost of medical care. Senator Leahy. How does the cost of the clinic relate to the

Dr. Hantman. These are the charges. Senator Leahy. These are the charges.

Dr. Hantman. The total cost of the clinic, the total budget for the first year is \$56,000, independent of the startup costs, which are covered under our grant.

Senator Leahy. What is the relationship then?

Dr. Hantman. The relationship is based—this would be a prorata affair in which the total billing would exactly match our total

We anticipate a total average cost per patient of \$13, that is per visit, lab tests, comprehensive examination.

Senator Leahy. Ms. Labroke, we have gone over the time, but is

there anything you would like to add? Ms. Labroke. I just have one thing that I would like to add.

Senator Leahy. Please do.

Ms. Labroke. Getting back to what Dr. Wilson was talking about this morning, we seem to find some people here today saying that we want to utilize nurse practitioners and physician assistants' services just because we cannot get a doctor in the community. I think that is approaching the situation a little bit backward. If we take an area like Danville and look at the comprehensive health needs of that community, and you look at some of the ways that can be appropriately met, you are really talking about a rural health clinic and not about a full-time physician in private practice. That is very inadequate use of both physician's time and the scope of care a clinic can offer. You also are probably not ever going to support a physician in that size area.

It is not second-rate care because you cannot get a doctor up there. The people need access to a doctor, which they have through the

formal relationship with the physicians that the clinic has.

By having a rural health center and not a private practice, you get a more accountable system of care in terms of quality control, peer review, community input, much more so than you would in any

private practice. It is therefore safer from things like medicare fraud and is good quality health care.

Senator Leahy. Thank you.
The next witness is Dr. Tufo, from Vermont.

Doctor, before you start your testimony, I noticed that in the last paragraph of your testimony, you say that you have one suggestion for our consideration.

To quote you,

This legislation speaks of the idea of development of a managed system. Therefore, you might consider a less technical definition of "physicians extender," and allow whoever accepts management responsibility to select people to fill needed roles. The technical definition in terms of care standards should be placed on the system.

That raises intriguing thoughts in my mind, and please go ahead with your testimony, but I would like some emphasis on that point.

STATEMENT OF HENRY M. TUFO, M.D., GIVEN HEALTH CARE CENTER, BURLINGTON, VT.

Dr. Turo. It also, Senator, should be placed in the record that I am a faculty member at the University of Vermont, because the university has lent its support to the Grand Isle project from its inception, both its moral support and, more importantly, financial support, through a grant from the Kellog Foundation.

Senator Leahy. And it is support that has been greatly appreci-

ated.

Dr. Tufo. Yes; and I think, extremely helpful.

It is my understanding that the intent of this legislation is to encourage development of primary health services in rural areas that are medically underserved. This encouragement is to be provided through removal of barriers for payment of services provided to medicare beneficiaries by nonphysicians. I strongly endorse this

It is, in my estimation, thoughtfully conceived and well written. It addresses and removes one of the major economic impediments to development of organized rural health services. Furthermore, this legislation links payment to cost rather than prevailing fee, to coordination of services, and to evidence that there will be ongoing

assessment of quality and utilization review.

These links are important to the development of a system of care. This legislation is unique because it states the needs for these links so clearly. Hopefully it can serve for a model for future health care

legislation.

I have been directly involved with the planning and operation of a rural health care center project in Grand Isle, Vt., for 3 years. The principles on which this center operates are similar to those called for by this legislation. My involvement stems from my belief, underscored by the experience provided in my own practice, that a managed system can lead to both improved quality as well as lower costs through better utilization of resources.

It is unlikely that the health needs of rural America can be met by simply training more physicians for a variety of reasons. Therefore it is important to develop approaches which demonstrate utilization of existing people resources effectively and stress coordination and reduction of fragmentation.

You have requested and I speak specifically to the questions of assessment of quality and provision of coordinated backup services.

Our experience is that it is possible to develop an audit system which provides both patient protection and continuing provider education. The audits of the Grand Isle practice, demonstrate that quality meets current excepted standards of care. Moreover, the simple provision of an ongoing audit makes this an unusual delivery system since, as members of this committee may realize, ongoing assessment of care is not generally a part of the delivery system.

The approach to assessment of quality of care we have used in Grand Isle is based on performance of the individual provider—physician, nurse or paramedical assistant—who operate within the ground rules of the system rather than audit based on the use of predefined criteria. This approach to audit relies heavily on the use of the problem-oriented system developed by Dr. Lawrence Weed who is now at the University of Vermont College of Medicine. This approach has been reported by my colleagues and myself in the medical literature which I have referenced in my written

testimony.

The provision of backup services are provided for in a contract that our practice group has with the Grand Isle Health Center. This contract defines responsibility for providing supervision, developing care protocols, and providing backup services. In practice these backup services are provided in a number of ways. If the nurse who is onsite at the practice feels that a need to review a problem, then the contact is made by phone. If the nurse feels that a patient problem requires physician review that day, then the patient is referred directly to the office or hospital. If the nurse feels that the physician review is required at on next visit, that patient is seen by the physician on his weekly visit. If more specialized services are required, then the patient is sent directly to the specialist.

It has been our experience that this backup service has worked very smoothly and that the majority of problems can be handled at the center by the nurse or at the time of the weekly visit by the

physician.

In summary I believe this to be a practical cost effective approach to solving our problems of access to care and upgrading the quality of care in medically underserved areas. I believe that the proposed legislation is timely and will be helpful in expanding this approach.

I have one suggestion for your consideration. This legislation speaks to the idea of development of a managed system. Therefore you might consider a less technical definition of physician extender and allow whoever accepts management responsibility to select people to fill needed roles. The technical definition in terms of care standards should be placed on the system.

Senator Leahy. I was concerned, reading some of the material

that we received on this, the number of people who emphasize how much they are in favor of having some type of nonphysician medical service available to rural areas, but then, some object to the

bill because of the various terms used in it. This struck me almost as saying that, if I have got to go from one floor to the other in this building, I can only go on the elevator that says, Senators only, and not on the others. The fact of the matter is, I normally use the stairs.

But you think that, rather than the term, it would be far more important to look at the actuality of it, and as you see the actuality being putting the responsibility on the particular system, however

Dr. Tufo. Yes, I do. I think it is much easier to define the technical requirements, it is much easier to allow the differences which exist between and among States, and even within the State, among regions of the State. There are different jobs that need to be done

in different areas of Vermont, even, as a small State.

Senator Leahy. This is one of the things that, perhaps, I have expressed a bit of a bias here today, in speaking of this as being legislation that was certainly designed to be for rural areas. My feeling is that Washington designs things for an average State, and there is no such thing as an average State. And if there is, it is not Vermont, and it is not Iowa, and it is not North Dakota, and you could maybe go on down through them, and list just about every one.

Do you feel that this legislation, as it is before you now, could be truly successful if we try to set it up as a broad health delivery form of legislation that will work equally well in urban areas as in rural areas-Dr. Tufo, why don't I start with you, and then go to

Ms. Davis and work up through.

Dr. Tufo. I am not sure, Senator, what you mean by successful. You would have to answer as to whether or not it was possible,

politically, to do that.

Senator Leahy. Perhaps, if we depart for a moment from the political question. Are we really talking about having roughly the same kind of systems, health delivery systems, as necessary—let us use the word necessary—as necessary for rural areas and for urban

Dr. Tufo. No. I think they will be different. When I originally read the bill, I think my initial impulse was to say, oh. Why not just simply make this a bill that encompasses both rural and urban

areas?

And then, as I thought more carefully about it and reread the

bill, my thinking really went in much the opposite direction.

I think that this, from my point of view, is a bill that is wellwritten, and well-conceived for rural areas. The problems in rural areas are different than problems in cities, and I think the bill as it is written, its intent is to provide and develop services in the rural areas. The problems are different in cities.

That does not mean that I do not believe the same general attempt or approach is needed, but I think that at that point, a bill might

be written specifically for urban areas.

Senator Leahy. Would everybody feel basically the same as Dr. Tufo on that? Ms. Davis?

Ms. Davis. I think one comment would be that since we are based on the problem-oriented system of care, I think that that in itself is applicable to an urban setting. But for the purposes of this legislation, I think that it is key to keep them as separate issues, because I do agree that their problems are different. But I think the system, that of utilizing nurse practitioners and problem oriented systems in itself is very applicable to urban areas-but

not the legislation.

Senator Leahy. Thank you. To go back to one other area—Dr. Tufo, again, speaking of the definition of physician extenders, within the concept that you use; that is, having the head of that particular system, whatever it might be, being responsible—would you still set national minimum training standards for-for want of a better term—medical extenders, nonphysician personnel, used within

these types of medical situations?

Dr. Turo. I don't think, as the gentleman from HEW proposed this morning, that that is an unreasonable thing to work for. And I believe there is already a development in that direction within HEW, in an attempt to define national standards for-national certification—for nonprofessionals giving health care. I do not think it is possible given the—the current state of the art does not allow that to happen tomorrow. But I do not think it is an unreasonable thing to be working toward.

Senator Leahy. Certainly, if we add legislation to allow these kinds of rural health care units, it would certainly be an impetus

to provide such minimum standards.

Dr. Tufo. Yes. But again, I emphasize, there is just so much energy in terms of where to place your effort, that the mileage that would be obtained from placing the effort on forcing definitions of systems would be far greater than the mileage one would get from trying to force definitions of what people do, in terms of training. That is my belief.

Senator Leahy. Thank you. On the question of supervision and I will direct this question to both Ms. Heath and Ms. LaBrokein your contact with physicians, do you ever have any questions in your own mind as to at what point you are totally on your own, or at what point you have a required contact with a physician? Is that

always something very clearly within your own mind?

Ms. Labroke. Well, I think—personally, I have a pretty clear idea of what I know and what I do not know. When a questionable situation develops that I have no protocol or experience to handle,

I call Dr. Hantman.

Senator Leahy. Maybe I should word it another way. Do you have a difficulty operating under a system where, at certain times, you are on your own, and at other times, you are going to seek contact with a physician; does that create a difficulty?

Ms. Labroke. Not at all.

Dr. Hantman. Much of this is defined by the protocols we have written, as a matter of fact. In certain situations, the nurse willin all situations of patients with crushing chest pain-say, call the physician. She does not have freedom of motion in that situation.

Senator Leahy. Do you find this protocol is adequate?

Dr. HANTMAN. We just started with ours.

Ms. Heath. Yes. Being under supervision of the physician is a big issue. I talked with nurse practitioners before leaving Vermont, and each nurse practitioner clearly said that there is a component of her practice wherein she is under the supervision of a physician.

And it is outlined in protocols, those areas where we have flexibility of action and those areas where we are to call the physician.

Also, until the protocols get developed, then you do have to depend upon the relationship and better defining the system, as Henry

We do have the option at any time not to do what the physician has suggested. We do not have the option at this point in health care to develop our own alternative medical intervention. For example, if Henry suggests to me that I use a certain medication, I can say I do not feel comfortable and will not do it, but I cannot substitute a medication.

Senator Leahy. How do you feel about the word, "supervisor" within the legislation, as it is used?

Ms. Heath. I guess I feel okay about it, because there are parts

of my practice where I am supervised.

Senator Leahy. Do you feel that the basic thrust of the legislation—that is, to get health care into rural areas where physicians are not available—is more important than what particular term is

used to describe you, for example?

Ms. Heath. If I had the option, I guess I would prefer to be identified as a nurse practitioner. But dwelling on the semantics becomes irrelevant when the importance of getting the legislation through is considered in accomplishing our goal of rural health services.

I think I have skills as a nurse practitioner which are unique, which physicians do not learn, which physician assistants do not learn, and the physicians have skills I do not have. But I think, as Henry said, it depends upon definition of the system, and maybe some other physician can provide the patient education that I say I am good at.

I think ultimately, it is the care you are trying to provide and

less dwelling on what happens to me.

Senator Leahy. Then would you agree with the statement made by Dr. Corbett earlier, that the legislation makes sense because it enables to focus more on the type of care provided than on the type of practitioner provided in the care. Should that not be our ultimate goal, what type of care is provided, and to whom?

Ms. Heath. Yes.

Senator Leahy. Does anyone want to add anything else?

Dr. HANTMAN. I would like to submit into the record a sample protocol which we have-

Senator Leahy. That would be very helpful.

Dr. Hantman [continuing] —which clearly outlines the situation. This is for use of analgesics for painkillers, and clearly outlines the situation under which the physician must be called.

Senator Leahy. That will be inserted at this point.

[The following was received by the committee:]

ANALGESIC USE-PROTOCOL

I. ASPIRIN O.K.

1. Aspirin 5 grains: 2 pills TID-QID. Warn: Bleeding, especially melena. If gastric irritation: take with milk, meal, antacid.

2. Propoxyphene compound (Propoxyphene 65 mgm + APC or aspirin) (Darvon Compound-65, Dolene Compound-65, SK Comp-65): 1 pill QID. Warn: Bleeding, drowsiness, nausea, dizziness.

Then (call M.D.)

3. Pentazocine (Talwin) 50 mgm: 1-2 pills QID. Call M.D. for prescription; will not be stocked in clinic. May use with aspirin. Warn: Drowsiness, nausea, constipation, dizziness.

Then (call M.D.)

4. APC Compound with 30 mgm Codeine: 1 pill QID. Call M.D. for prescription; will not be stocked in clinic. ASA Compound #3, Empirin Compound #3, etc.). Warn: Nausea, drowsiness, bleeding, constipation, dizziness. All patients on codeine: M.D. consult after first 2 weeks; first prescription to be written for no more than 2 weeks, with no refills. For patients in whom codeine is used longer than 2 weeks, must be seen monthly or more frequently. Repeat MD. consult after 2 months.

II. ASPIRIN CONTRAINDICATED

Ulcer, hiatus hernia, peptic disease, bleeding, on anticoagulants, steroids, Indomethacin (Indocin), other anti-inflammatory drugs (Phenylbutazone (Butazolidin), Tandearil, steroids), aspirin intolerant.
1. Acetaminophen (Tylenol, Nebs, Phenaphen (new formulation), others)

5 grains: 2 pills TID-QID. Abbreviated ACAP. Warn: None.

2. Propoxyphene 65 mgm plain (Darvon 65 mgm) OR Propoxyphene Napsylate 100 mgm with or without ACAP (Wygesic, Darvocet-N, etc.) Warn: Nausea, drowsiness, dizziness.

Then (call M.D.)

3. Pentazocine. See above.

Then (call M.D.)

4. ACAP with Codeine 30 mgm (Tylenol with Codeine 30 mgm, etc.). Ca 1 pill QID. Warn: Nausea, drowsiness, dizziness, constipation. All patients on codeine: See above.

Senator Leahy. I thank you very much for coming down. I also thank you for the tremendous help that you have given me during the past couple of years on this subject, both here and in Vermont. Our next panel is composed of individuals who have special ex-

pertise in topics directly related to the problem we are discussing

today.

Dr. John Runyan, Jr., M.D., chairman of the Department of Community Medicine, University of Tennessee College of Medicine, Memphis, Tenn., will discuss quality of care and hospital utilization in areas served by physician extenders.

Stephen Caulfield, assistant director of regional operations, accompanied by Dominic Raino, staff director, health financing and reimbursement, United Mine Workers of America Health and Retirement Funds.

Oliver Fifield is the president of Blue Cross/Blue Shield of New Hampshire, and Vermont, Concord, N.H. He represents two organizations that currently allow reimbursement for clinic services, and we will learn from them about their modes of reimbursement.

As I mentioned earlier and mention again for the record, I am personally familiar with what Mr. Fifield has done, in efforts to allow us to establish whether a private insurance plan can work as an aid for physician extenders, nurse practitioners, however we may define it. I think that he deserves very much the thanks of this committee and of the Congress, in making such an effort so he can provide for us information that is not based just on theory, but information based on practice.

Ralph Borsodi is an economist with the American Association of Retired Persons/National Retired Teachers Association, and now works a farm in southern Pennsylvania, and that has to give you

as close an eye of rural life as possible.

Archie Golden, M.D., is chairman of the Government relations com-

mittee, association of physician assistant programs.

I would emphasize again—and unfortunately it is what happens but so often with our panels, when we try to put everything in on 1 day—and I know a number of you have sat here and listened to a great deal of testimony; the various rumbles I hear from the back are the collective stomachs of people who have gone without lunch, and if it is any consolation, I have too-I would ask you to limit your statements. All statements will be put in the record

I might suggest that each one of you, if you would like to emphasize one point, if you could just-again, all your statements will be in the record. They will be read, if they have not already been, by each member of this subcommittee, and certainly, before any votes

are made by the committee on the legislation.

I would like you to emphasize any one point that you would want us to remember, if we remembered nothing else, and also, feel free to remark—one of the advantages of your being here is that you have heard all the testimony—feel free to remark about anything that you have heard, either for or against anything you have heard here today, and I will start with Dr. Runyan.

STATEMENT OF JOHN W. RUNYAN, JR., M.D., CHAIRMAN, DEPART-MENT OF COMMUNITY MEDICINE, UNIVERSITY OF TENNESSEE. COLLEGE OF MEDICINE, NASHVILLE, TENN.

Dr. Runyan. Thank you, Senator Leahy. I will try to keep it brief.*

Our studies indicate that in the system of health care delivery in Memphis and Shelby County, operated by the health department, initiated in 1963, that the nurse in an extended role utilizing written protocols with physician and medical center backup can provide services of high quality.

Currently, there are 26 decentralized clinic locations in both urban and rural areas of the county where this care is provided, for a population of about 225,000 out of the county's 750,000.

^{*}See p. 159 for the prepared statement of Dr. Runyan, the balance of his submitted material will be retained in the committee files.

The studies relating to quality of care and hospital utilization that have been underway for the past 6 years involve a subset of the chronic disease population of 10,000 of which 90 percent have hypertension, diabetes mellitus, and cardiac disease.

The blood pressure levels in hypertensive patients are maintained within an acceptable range in 95 to 96 percent of patients with a

follow-up rate of 75 percent over the past 5-year period.

These results compare favorably with those under physician care in the city hospital and with research studies being conducted on a national level by the National Heart, Lung, and Blood Institute, which I have had the privilege of being a member of their committees.

There is a reduction after transfer to this decentralized network of 52 percent in hospital utilization for these hypertensive patients with a significant decrease in the occurrence of stroke and congestive heart failure which are known to be complications of inadequately

controlled high blood pressure.

For patients with diabetes mellitus hospital utilization is decreased by 49 percent. After 4 years, over 70 percent of the initial diabetic population is being followed with average blood sugar levels maintained within satisfactory levels as outlined in the goals of therapy in our protocols which are published as the "Primary Care Guide"—and I wish to submit this to you as a single copy, Senator Leahy.

Senator Leahy. This will be made available to the committee. Because of its size, it will not be printed as part of the official

record, but it will be here and available to the committee.

Dr. Runyan. Thank you.

Hospital utilization for the preventable complications, such as diabetic acidosis—the extreme form of diabetes—severe infections as a result of uncontrolled diabetes and lower extremity amputations from poor blood supply and infection of the feet are significantly reduced.

In an entirely rural care system operated in Kentucky by nurses with physician backup—for example, Frontier Nursing Service hospitalization rates for diabetic patients are also considerably less than the national average.

The average number of days spent in a hospital nationally per year by diabetic patients is 5.4, while in the Memphis and Shelby County program, it is 1.68 days and for the rural Kentucky Frontier

Nursing Service, it is 1.6 days per year.

In urban Los Angeles, when ambulatory care was made more accessible to diabetic patients, including the use of physician extenders, there was a reduction of 5.6 to 1.74 days per year.

Since in our program, ambulatory and home care are emphasized, overall health care costs are significantly reduced for each day that a patient can be kept out of the hospital can pay for many ambulatory and home care visits.

Physician extenders trained in primary care are oriented toward ambulatory and home care which are the most suitable locations to administer to the chronically ill and elderly, unless hospitalization becomes mandatory.

The benefits to their health and well-being that elderly people receive upon hospitalization is often questionable and certainly many do better in the familiar surroundings of their own home or in a clinic with devoted, friendly professionals and personnel.

Since home care is such an important extension of health services,

I would suggest that its availability be considered as a criteria to

qualify for medicare reimbursement for rural clinics.

Other medical services are offered adults as well as other age groups by the Memphis and Shelby County network of clinics, including episodic care of common problems and self-limited ill-

However, my research has not extended to these other services but of course, they are essential for a rural clinic. Even though I have no personal data, other reports and our own experience suggest that physician extenders can be very effective in providing these services.

It would be my opinion that bill S. 708 has those essential ingredients that would promote high quality and safe care for the rural elderly, particularly if some type of home care services could be provided. I have entered the published papers that have arisen from our work in Memphis and Shelby County.

Thank you.

Senator Leahy. Thank you, Doctor. Incidentally, I notice that your studies concentrate on both hypertension and diabetes. Is this because those two diseases account for a large part of the hospitalization among the elderly?

Dr. Runyan. That is correct; that and its complications.

Senator Leahy. I see. Is a quality review mechanism important? Dr. Runyan. I think that it is essential for this to be inserted in individual clinics, or if you have a network of clinics involved in this. I think that some type of audit is essential.

Senator Leahy. The next witness is Mr. Caulfield, the assistant director of regional operations, United Mine Workers of America.

Mr. Caulfield?

STATEMENT OF STEPHEN C. CAULFIELD, ASSISTANT DIRECTOR, REGIONAL OPERATIONS, UNITED MINE WORKERS OF AMERICA, HEALTH AND RETIREMENT FUNDS

Mr. CAULFIELD. Thank you, Senator Leahy. I will depart entirely from my written testimony and focus briefly on an aspect of this legislation that has not received very broad discussion during this morning's testimony: The question of cost-based reimbursement.*

The health and retirement fund of the United Mine Workers are a multiemployer Taft-Hartley trust, that have the responsibility of making accessible and available a reasonable quality—we hope, a high quality—of health care to now some 820,000 bituminous coal workers, survivors and their dependents, primarily in the Appalachian corridor, but in a number of the States in the West.

We have attempted to deliver this care over the last 30 years though a variety of purchasing mechanisms. Four characteristics of our program may make our testimony on S. 708 of some relevance.

^{*}See p. 163 for the prepared statement of Mr. Caulfield.

First: Unlike most other third parties, we have a rich 30-year history of dealing almost exclusively in rural America. We have been aggressive in the organization and delivery of health care through unique purchasing arrangements and administrative interventions.

Second: We have, from almost the outset of the physician extender concept, fully supported and reimbursed for physicians' assistants and nurse practitioners, as though they were physicians, because we in truth believe, as Dr. Corbett so eloquently stated this morning, that what we are purchasing is care, and not indi-

viduals who are delivering that care.

Third: We have a very unique arrangement with the Social Security Administration, for coverage of part B service under medicare. We are what is known as a group prepayment practice plan, which means that physicians who are treating our beneficiaries bill us without regard to whether they are medicare-eligible or not. We in turn get reimbursement from the Social Security Administration, even though we are not a direct deliverer or care.

Thus, providers of care are blind to the sources of insurance for our beneficiaries, and there is no subtle discrimination in the care rendered to those who are covered under one program and those

who are covered under another.

And finally, we have, over the years, favored a costbased reimbursement mechanism, as opposed to fee for service mechanism.

Let me move quickly into the cost-based arrangements and talk

very briefly about that.

Let us be very candid. This administration and this Congress are concerned about both cost and fraud and abuse. We think there is potential for controlling both, through the aggressive use of pros-

pectively negotiated cost-based arrangements.

What we have done historically with our larger providers is to set costs based on five considerations. Very briefly, they are these. What is an adequate level of compensation for personnel? What is an adequate level of productivity—and I would urge that this committee address the question of productivity, because when you do move from a fee for service base to a cost base, you do tend to depress productivity, unless there are some built-in standards or incentives. The American system of medicine does not pay for the treatment of episodes of illness; we pay for encounters. And until we turn that around, we are going to have to build into the system some productivity standards.

Third: You have to look at the allocation of resources.

Senator Leahy. You realize you are asking for a revolution in some areas.

Mr. Caulfield. Well, we have been attempting to create some small revolutions in rural health care for 30 years, and—

Senator Leahy. I'm not objecting to it.

Mr. CAULFIELD.—and it works.

The third thing is that you have to look at the allocation of resources. One of the things that troubles us is that when a physician moves from individual practice into a costbased group practice, they may want to have all sorts of elaborate and costly facilities

available to them. And we think that if you hold down these costs, by aggressively negotiating what is appropriate for that particular practice and location, you may make some inroads there.

Fourth: We think a commitment to the future has to be made and built into the cost, in terms of recruitment, continuing educa-

tion, quality control, and maintaining capital facilities.

And finally, we think that there has to be some incentive to "close" the system. Thus, we are attempting to put the outpatient side at some risk for the inpatient utilization, in the costbased negotiating

arrangements.

One word on prospective arrangements. The American public has been outraged at cost overruns in the defense industry. If they were aware of the kind of retrospective adjustment that third parties—including ourselves, until very recently—have made in the health industry, I think they would be equally outraged.

We are going to have to put the burden of management where it belongs; on those who deliver. We are going to have to go on some prospective ratesetting and prospective reimbursement mechanism, if we are going to get a handle on controlling the cost of care.

Mr. Harf, on the staff of the committee, asked me some weeks ago whether the resources are available in rural America to establish

these kinds of cost-based arrangements, and I said there are.

As you know, Senator, there are a variety of high-quality small businesses among your constituents, who have the same kind of budgeting problems that exist in a rural clinic. There are certified public accounting firms available to rural America, just as they are in urban America. I think that if we put our minds to it, if we establish appropriate guidelines and regulations in our larger clinics, we can move effectively toward cost-based arrangements, and I would urge that that portion of the bill receive particular attention.

In conclusion, let me highlight several other points. We favor the provisions on quality control, and on certification. We feel that independent practice is something that we do not favor, and the level of supervision specified in the bill fully meets with our requirements.

The question of the span of control of the supervising physician has not been addressed in these commandments. One of the concerns I have heard expressed with regard to extending this bill to cover urban settings is the kind of fraud and abuse that has been attrib-

uted to "medicare mills" in urban areas.

We, as a third party, would not be opposed to an amendment which would specifically address the span of control; that is, how many physicians' assistants, can one physician adequately supervise.

And I offered in my testimony a number of two. I think that is within the range of the acceptable. I think it could go up one or two, but I think that is something you may want to consider.

Senator Leahy. Are we not better off, though, in designing this as a rural bill, with the peculiar problems of rural areas, and looking in all likelihood in other legislation at the use of nonphysician medical personnel in an urban area, even though there may be certain aspects of the design that would be the same in both of them?

Mr. Caulfield. There is a logical desire to have one system of care. We clearly are advocating for high quality care for rural America, and therefore, I am hard-pressed to argue against you.

However, I would say that we have learned that the system of incentives works sometimes in circuitous ways, and we have to be very careful when we construct a two-tiered system, that we know all of the counterintuitive ways that that system of incentives may work, so that we do not, a year from now, find that we are amending this to correct some disincentive to rural practice that may have been created by a two-tiered system.

Senator Leahy. I understand. I also am aware, in looking at housing programs, and so many other programs, that are designed to take care of people somehow we find it so convenient to become

biased to the urban areas.

I am not saying that there is not poverty and housing problems in urban areas. Of course, we have a social responsibility there.

But when the same problems exist both in rural and urban areas, and a disproportionate share of our money goes to the urban areas, certainly as a Senator from a rural State, it creates concerns in my mind.

Incidentally, does United Mine Workers have guidelines or standards for limiting eligible costs that might be shared—that you might share with the committee, even if you want to send it in at a later date?

Mr. Caulfield. Yes, we have some guidelines, and I can get

those to Mr. Harf.

Senator Leahy. Yes, would you please, and we will put them in the record.

[The following information was subsequently received:]

UNITED MINE WORKERS OF AMERICA, HEALTH AND RETIREMENT FUNDS

PROPOSED GUIDELINES FOR FUNDS—COST BASED RETAINER AGREEMENTS WITH GROUP PRACTICE CLINICS

Description and applicability

A cost based retainer is prospectively negotiated using a combination of actual costs from previous periods and budgeted costs, including the cost of proposed changes in programs and services during the period for which the retainer will apply. The incurring or budgeting of a cost in itself does not justify inclusion of that cost in the Funds' retainer amount. Some costs may be limited or excluded.

This system or arrangement is most suitable for an organized health care delivery system. It gives the Funds an opportunity to influence the delivery of health services in situations where there is a concentration of beneficiaries. It has also been used to encourage the formation of multi-specialty group practice clinics in areas where there is a lack of readily accessible health services. It represents an advanced degree of Funds involvement in joint planning. Under certain conditions, it may also be feasible for individual physicians or small partnerships as well as hospital-based group practices.

Guidelines for allowable costs

A. Current Operating Costs

Current operating costs include employment costs such as, salaries, wages, employee fringe benefits and payroll taxes, professional compensation, contracted service fees, and non-salary expenses such as, insurance, non-capitalized maintenance and supplies.

The reasonableness of each of these costs should be evaluated. Each cost can be evaluated in the aggregate or, if appropriate, on a departmental basis

using the following measures for comparison with similar providers or with a pre-established standard.

1. Productivity. This is the ratio of the output units such as x-rays, patient

visits, etc., and the input units as defined in dollars, labor hours, etc.

2. Wage rates. The dollar rate per hour for each category of employee or for each department should be considered. These rates may vary from one area to another and should be updated at least annually by each Regional Office.

3. Use rates. Analysis of the number of x-ray or laboratory procedures per patient or patient visit, as examples, can provide insights into the budget structure. Use rates should be compared with those of previous periods and with those of similar providers. The Surveillance and Utilization Review Program in the MINES system is designed to provide data for this purpose.

B. Research and Education Costs

Providers should fund research and education costs (both direct costs and overhead) through grants, scholarships, tuition, gifts and other external sources. Under certain conditions, the Funds may financially support these activities. Before such costs are included in a retainer agreement, however, approval should be obtained through the Office of Regional Operations in Washington. D.C.

C. Credit Losses and Charity Care

The cost of services rendered that are ultimately written off as credit losses or charity care are included in the current operating cost determination. An analysis should be performed of the providers collection policies and procedures and the reasonableness of these write-offs should be determined.

D. Capital Requirements

Elements of cost related to capital requirements should be considered separately from operating costs in establishing the retainer amount. Several of these costs are generally included in the providers financial statements as current operating expenses but are closely related to capital budget considerations.

1. Depreciation. Historical cost depreciation may be included in the allowed costs determination. The amount of such depreciation may be limited to the extent it is applicable to idle or non-patient care related assets or to assets not approved by a certificate of need agency. Depreciation on assets used by the provider to render services not included in the Funds' benefit program should not be allowed.

The amount of depreciation allowed for each period must be placed in a plant and equipment fund and used to provide for budgeted capital expendi-

tures including items 2 and 3 following.

2. Interest. Interest expenses incurred in financing capital projects or working capital are allowable costs. Limitations identical to those placed on depreciation cost may be imposed. The interest cost may be limited if not reasonably related to the current market rate for money. Interest cost may also be offset by interest income earned on funded depreciation or other operating funds.

3. Debt amortization. The dollar amount required by the debt retirement schedule in the debt instrument may be included in allowable costs if they are reasonably related to the estimated useful life of the mortgaged asset.

4. Lease expenditures. The cost of true lease agreements may be included in allowed costs to the extent the lease agreement cost does not exceed the price level depreciation plus interest expense which would be incurred if the asset was purchased rather than leased. The limits which may be imposed on depreciation expense should also be applied to lease expenses.

5. Additional capital needs. As the provider identifies specific capital expansion or replacement needs, the Funds should consider each on a case by case basis. The cost of such capital projects should first be met by the depreciation cost allowance. If this allowance is not sufficient the Funds will consider including additional capital costs, either through cash purchase or by supporting the cost of additional debt.

New capital projects generally have considerable impact on operating costs for future periods. These future costs should be considered when planning new

services or programs. If a capital cost is disallowed by the Funds but the provider proceeds with the project, consideration should be given to excluding from allowable costs new operating costs resulting from the project in future

Senator Leahy. Also, how many beneficiaries are in the UMWA? Mr. CAULFIELD. We have about 820,000, and of that group, about 120,000 are medicare-enrolled, and that represents roughly oneseventh of our population. About one-fifth of our \$220 million annual expenditures on the health care side is attributable to those medicare-eligible beneficiaries. So there is more paid out on their behalf than on the rest of the population.

Senator Leahy. I understand.

Mr. Fifield is the president of Blue Cross/Blue Shield. I am glad to have you here, and again, a gentleman who has been very kind with his time, not only down here, but also testifying before our committee in Vermont, and who has withstood the onslaught of mail, letters, requests for response from my office, and has responded. Go ahead, sir.

STATEMENT OF OLIVER R. FIFIELD, PRESIDENT, BLUE CROSS/BLUE SHIELD OF NEW HAMPSHIRE AND VERMONT, CONCORD, N.H.

Mr. Fifield. Thank you, Senator Leahy. I will not read my statement. I have extracted, I think, just four quick points, and will respond to those.

Senator Leahy. The whole statement will be made part of the

record, though.*

Mr. Fifield. This is my first trip to Washington, D.C. to testify, or to even appear or to be present at one of these hearings, and I can understand how Senators get to be so intelligent after awhile, with the amount of information-

Senator Leahy. Well, we end up hearing a lot of information, but we do not necessarily get to be intelligent. I could show you mail that comes to my office, from people who disagree completely.

[Laughter.]

Senator Leahy. Go ahead

Mr. FIFIELD. I will only talk to four points.

The need is apparent, as we see it in Vermont and New Hampshire, for nurse practitioners or physician extenders, to provide some health care service, simply because there are not physicians

available or willing to live in some of these areas.

I think it is also obvious—and this is one point I would stress over others—that the need in a rural area is different, and therefore, ought to be handled separately. There are problems in the urban areas, but they could be handled under another piece of legislation. I do not think we ought to try to mix the two.

No. 3: I am personally enthused about the cost reimbursement system that we are using, for some of the reasons that the previous gentleman mentioned, but also for what may appear to be some

pretty mundane kinds of reasons.

^{*}See p. 167 for the prepared statement of Mr. Fifield.

One in particular is that it eliminates an awful lot of paperwork. And if you have been associated with people who are involved with insurance programs or Government programs, there is a great deal of frustration that goes with claim forms, explanations and so forth.

We look upon this as an opportunity to simply provide some money, and then ask these people to manage it, to provide the services they think are reasonable within those goals. And that, in itself, will present an opportunity for utilization review and some real management of medical care dollars.

And finally, I would simply say that medicare dollar support is necessary, if we are going to really establish and encourage these

rural health centers.

I therefore am very much in favor of Senate bill 708.

Thank you.

Senator Leahy. Thank you. As I mentioned earlier, what you are doing in Vermont is particularly valuable, because we end up so often making decisions on bills down here, by determining something in the abstract. Maybe we will come back afterward, and maybe we won't, to see whether it has worked. And if it turns out to be an unmitigated disaster, we will all express that it really wasn't what we wanted, and why didn't the President veto it to begin with. Another way we proceed is to put together some kind of an expensive trial program, increase the bureaucracy, and increase the money, and so on, and try to see if it works.

crease the money, and so on, and try to see if it works.

And here, you have been involved in private industry. You have put this together in private industry, on a trial basis. So I think your testimony will be particularly valuable to us. And I have discussed it with a number of members of the committee already.

They are interested in finding out about your experience.

Do you see that this can be done in such a way that you can be very satisfied with your own accounting procedures? That is, a method of payment such that you can be comfortable in presenting it to your own board of directors and justifying it before ratesetting boards, and justifying it before those who look at your profit and loss statements?

Mr. Fifield. Yes; I think we can. I think we already have, within the framework of our present agreement or contract with this particular health center in Grand Isle, most of the ingredients for controlling, from our point of view, what the costs are going to

be, and those that we are going to be responsible for.

I think that also gives them a guarantee, in the sense that they can budget, then, toward what they can expect to at least receive

from one payor.

I think one of the things that it will do is make people more realistic, in the sense that there is a limit to how many dollars, for instance, can go into a certain community, whether rural or otherwise. And the staffing pattern would have to be set, I would assume, after some negotiation as to how many dollars are going to go there.

Senator Leahy. And utilization review can be done adequately, even though individual bills are not submitted for each service?

Mr. FIFIELD. I believe it can. The process we are using right now is a ledger, or just a listing, billing, once a month. We use that actually as our claim form document. We make a photocopy of it, after we have found that these people are eligible, and it then becomes a support item, as an invoice, and we issue a check.

Senator Leahy. What you are doing seems too sensible and too reasonable to ever be accepted by the Federal Government, but we

can always try. [Laughter.]

Mr. CAULFIELD. Senator, I would also like to point out that we also use that method of billing for cost-based arrangements, which carries with it descriptions of the patient, the service rendered, but no fee is associated with that.

The information provided enables us to do the statistical analyses necessary, but we do not collect fee information on these pa-

tients.

Senator Leahy, Mr. Borsodi?

STATEMENT OF RALPH BORSODI, REPRESENTING AMERICAN ASSOCIATION OF RETIRED PERSONS AND NATIONAL RETIRED TEACHERS ASSOCIATION

Mr. Borsodi. Mr. Chairman, the National Retired Teachers Association and the American Association of Retired Persons now have 10 million members.

We have given an enormous amount of study to the medicare problem, and it is very difficult for me to summarize our position

in a few minutes.*

I would like to say that our associations support the passage of S. 708. But we have a great many reservations on reforms to the medicare system, which we would like to see go through, because we feel that unless some reforms are made, the way the Government is expending money on health, that all reforms are in jeopardy.

We do not see how the inflation in the health care sector can continue at the rate it has in the past. So we feel that while these reforms, such as your bill, are desirable, that attention must be paid to the payment mechanisms. They have to be reformed.

The Government cannot continue to give what is a blank check to providers. We have to use disbursement methods for Government funds, which the Government over decades of experience has found necessary in Government disbursement.

So that the thrust of our remarks is that we endorse the bill, but we feel that it is essential to reform the whole disbursement

system of Government funds in the health field.

Senator Leahy. Give me an example of a couple of those reforms,

Mr. Borsodi. Well, essentially, the medicare disbursement is on a cost-plus basis. Now, as you know, when the Government dis-

^{*}See p. 171 for the prepared statement of Mr. Borsodi.

burses funds for an airplane on a cost-plus basis, there are elabo-

rate safeguards surrounding the profits and-

Senator Leahy. Let me emphasize, there are some of us who think that when we have cost-plus deals for airplanes, that the safeguards are not all that elaborate. We have one airplane with \$1 billion cost overrun on wings alone, making it the only airplane where the wings are optional equipment. [Laughter.]

Mr. Borsoni. I agree with you. But I have had considerable ex-

perience in the last war on the contractors' side of the Government

controls on cost-plus disbursement.

What I am saying is essentially, the system which works is based on cost-plus disbursement. We have tabled in our statement reforms that we think are necessary in disbursement procedures to stop this hemorrhaging of Government funds.

Senator Leahy. What percentage of the elderly—and you represent them—what percentage of the elderly's budget goes to health

Mr. Borsodi. Well, there is a new CBO study that came out about 2 months ago, that was quite startling. I would say probably about 10 percent. What was discovered in this latest study was that about 50 percent of the elderly are being kept above the poverty level by Federal funds—social security, plus food stamps, plus medicare—so that what I find is that it is difficult, because the statistics simply are not clarified, but I would say that at least 10 to 15 percent.

Senator Leahy. How much of that goes into hospitalization?

Mr. Borsodi. Do you mean under the medicare program?

Senator Leahy. No. I mean for the elderly. How much of their medical costs are associated with hospitalization?

Mr. Borsodi. I would say between 60 to 70 percent for institu-

tional care.

Senator Leahy. And would there be a cost reduction, do you think, because of reduced hospitalization, if we had a bill along the lines of S. 708?

Mr. Borsodi. Yes. We would like to see health care directed away

from hospitals, into outpatient, all types of outpatient services.

Obviously, the hospitals are terribly expensive, and should be used for treating acute illness.

Senator Leahy. Do you see the Clark-Leahy legislation doing

that?

Mr. Borsodi. Yes, we do.

Senator LEAHY. Thank you very much.

Dr. Golden, the chairman of the Government relations committee, association of physician assistant programs.

Dr. Golden, go ahead.

STATEMENT OF ARCHIE S. GOLDEN, M.D., CHAIRMAN, GOVERN-MENT RELATIONS COMMITTEE, ASSOCIATION OF PHYSICIAN ASSISTANT PROGRAMS*

Dr. Golden. Just to keep this in the Vermont context, Senator Leahy, I want to tell you that I had 4 enjoyable years in Vermont, and I am a graduate of the medical school of Vermont.

^{*}See p. 174 for the prepared statement of Dr. Golden.

I would like to state a little more of my background, as a context for a couple of the points I want to make—and I only will

make three.

Since leaving Vermont, I have spent time practicing in innercity New York City, practicing outside of the Federal System, with Navahoe Indians in Arizona, in the Rio Grande Valley of Texas, and more recently, in inner-city Baltimore; I am on the faculty of the Johns Hopkins University School of Health Services.

First, I would like to correct, I believe, some misstatements or misconceptions this morning of some of those who gave testimony.

In order that there be reimbursement of medical services provided by physician assistants or nurse practitioners today, the physician has to see that patient also. If the physician is down the hall and does not see the patient, or out of the county or out of the community, that visit is not reimbursed. That is one clear difference from what was said earlier.

I would like to go on to say that we are pleased with and do support S. 708. However, we would like to see it amplified and

adapted.

First, having to do with medically underserved rural areas, even though Dave Harf said that they could be adapted or interpreted to include physician practices in rural, medically underserved areas, we do not believe that this bill says so now. And as a result, only reimbursing clinics would only attend to the needs of possibility—and it is a very loose possibility—100,000 people in the whole country.

Senator Leahy. I think you are raising a point that I frankly

admit that I had overlooked.

I think our bill could be probably more specific there. Why don't we try to draft up some language Senator Clark and myself and the others.

Dr. Golden. It would certainly help the needs of medically un-

derserved rural areas.

Now, on the question of rural versus urban, you have made your-self very clear on that point, and I certainly understand that—

Senator Leahy. I have tried not to hide any basic prejudices

here [Laughter.]

Dr. Golden. And I understand the bias you say exists here in Washington, toward urban areas, in the past. I just wonder if there

is a way to write legislation so that will not happen.

I have had experience with both areas. I have done research in both areas and looked at the research of others, and frankly speaking, comprehensive health care for populations in inner city, underserved, and rural underserved are very similar.

I do not think a bill that would be written for urban under-

I do not think a bill that would be written for urban underserved would have different features. I heard you discuss the transportation problem that is there. But as far as the health services

themselves, I believe they are very similar, if not identical.

And I do understand the concern about possible fraud and abuse. I endorse what Steve Caulfield said. I think that writing in criteria that would limit the number of physician assistants or nurse practitioners per physician would help control that.

Therefore, I feel extension to other areas should be looked at very seriously, and ought to be included. I would hope that would

be a minimum.

We know that there are physician assistants and nurse practitioners practicing throughout the country, and we would hope that measures could be taken with all due speed, to see that their services were reimbursed in the future—not only those in underserved areas. We understand the underserved, whether rural or urban, should have top priority.

Just one other point. We feel that these services are medical services and should only be reimbursed when these medical services are performed under the responsible supervision of a physician

or physicians. Thank you.

Senator Leahy. Well, do you think that clinics in urban areas abide by different or additional requirements, as compared to rural clinics?

Dr. Golden. No. I am suggesting that a limitation of two physician assistants per physician should be applied in all areas, to

counter any possible abuse.

Other than that, I would think that fraud and abuse could be handled by the other legislation that is being taken up in the

Congress today.

Senator Leahy. Thank you, Doctor. I appreciate your being here, and I appreciate it especially because of the varied and, I would say, very practical experience you have had since you have left Burlington.

Dr. Golden. Thank you.

Senator Leahy. Before I call the next panel, I want to emphasize that anybody who has testified here today, if, after you get home, you start thinking about this, and you think there is anything additional that we should know or should hear, do not hesitate to write to me or to Senator Clark or to Dave Harf, with additional material. We will be happy to add it to the record.

The professional groups panel is made up of Fred Mondragon, president of the New Mexico Hospital Association, representing American Hospital Association, with Leo Gehrig, M.D., senior vice-president of the American Hospital Association; Edgar T. Beddingfield, M.D., chairman of the council on legislation of the American Medical Association; Anne Zimmerman, registered nurse, and president of the American Nurses' Association; Dan Fox, a physician's assistant and president-elect of the American Academy of Physician Assistants.

Now, I would emphasize to this panel that the committee ap-

preciates very much the patience of this panel.

The panel is asked to concentrate on specific suggestions for improving S. 708. If there are criticisms of parts of S. 708. I would ask that they be accompanied with concrete recommendations of how the particular panel member would change it. Such criticism is naturally—and this would apply to any panelist who has testified here—criticism without a concrete recommendation really is of little or no value to the committee or the Senate.

I would also start out by saying now that we have gone past the 2 p.m. closing time of this committee, and I understand we have received permission to continue past the 2 p.m. time.

We will put into the record the full statements of each one of the witnesses, so that they will not have to feel constrained to go

through and read them individually.

I would ask the witnesses to refer to those portions of their testimony that contain any recommended improvements, if they feel that there are some that should be made.

We will begin with Mr. Mondragon and Dr. Gehrig.

Dr. Gehrig?

STATEMENT OF LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY FRED E. MONDRAGON, PRESIDENT, NEW MEXICO HOSPITAL ASSOCIATION, ALBUQUERQUE, N. MEX.

Dr. Gehrig. I am the senior vice president for the American Hospital Association. Mr. Mondragon is with me, and I shall be very brief. Mr. Mondragon, being on the firing line, I know you will be

interested in what he says.*

The AHA represents some 6,500 hospitals across the country, and we basically support your bill. We believe, in addressing an acute rural issue, it is appropriate. I join you with regard to if it is applied to an urban area, we would view other problems as having to be addressed. We, however, support strongly its direction in terms of assistance to the rural area.

My testimony, for example, recognizes that in the bills introduction, there were comments about the definition or better, just the terminology to identify these individuals. I am not sure we have found the correct label, but we suggest that you may want to consider these individuals as nonphysician primary health care providers, which tends to cover a broader scope. Some have considered the title—physician assistant—as a limiting type of nomenclature.

Senator Leahy. You understand my concern, with all due respect to the medical profession, that I see it also like the question of the "Senators only" elevators and the public elevators. I find that I get to the floor I am going on either one, by whatever title it is called, and that I certainly want the titles so we all know who we are talking about, but that I would hope that if this bill is valid for a rural area, and if it solves a need that is there, that we not get hung up on just what we call it.

If I were a person who felt my life was dedicated to providing that kind of medical service, I could care less if they called me section 1, section 2, section 3 person, whatever, as long as I was in a position to provide the health care. But I think that you raise a very valid point, because a number of people have questioned just

what term should be used.

Dr. Gehrig. Well, it is only a suggestion, and I would like to move ahead.

^{*}See p. 178 for the prepared statement of Dr. Gehrig and p. 180 for the prepared statement of Mr. Mondragon.

Senator Leahy. And it is helpful to us because of that.

Dr. Gehrig. In looking at other areas, we have also addressed the matter of training and experience, only indicating that we are supportive of both the provisions within the bill as they presently stand. And Mr. Mondragon will have other comments in this particular area.

I believe we would better spend our time on his comments, but again, as I indicated, we support your approach to the broad issue that you are addressing. We view it as an expedient method of reimbursing an important practitioner that already exists in many areas. Your bill will assist in maintaining the very fiscal integrity of some of the rural clinics that are being challenged because of the inability to pay for these people through the medicare program.

With that, I would like to turn this opportunity over to Mr.

Mondragon.

Senator Leahy. But you also see a split between its use in a rural area and an urban area?

Dr. Gehrig. Yes, sir, I do. Senator Leahy. Thank you.

Mr. Mondragon. Thank you, Mr. Chairman.

My name is Fred Mondragon, the regional administrator for Presbyterian Hospital. I am also president of the New Mexico Hospital Association and a member of the State house of representatives.

Rural New Mexico has one of the lowest physician-to-population ratios in the country. The ratio is 1 to 1,400, excluding the area in

Albuquerque.

I will skip over my first couple of pages. Suffice it to say that we do have a serious deficit problem as far as physicians are concerned. Senator Leahy. They, plus the chart, will be made part of the

permanent record.

Mr. Mondragon. Fine.

We do have something like 30 to 40 clinics throughout the State, about half of which are staged primarily with nurse practitioners, that are really marginal in terms of their fiscal stability. They are very close to break-even, but they are not break-even. And it is felt that, by most of the clinic directors that I have talked to, that this law, your proposal, would make the difference between break-even and fiscal stability and the possibility of their going under.

I would say that New Mexico does have a permissive law which again permits remote supervision of both physician assistants and

nurse practitioners.

On page 3, I would just say that those rural elderly patients, paying the monthly medicare part B fee are disenfranchised from medical care for which they are paying if they cannot get the medical care.

In addition to that, the postponement of needed care tends to aggravate controllable diseases and leads to increases in total costs

of crisis care.

It is paradoxical that medicare reimbursement is not always provided for rural physician extender, in light of the stated goals of the rural health initiative program, the health underserved rural area program, Public Law 93–641, and other Federal laws.

In addition to that, regarding the bill itself, we do concur with

the standards for rural health clinics as defined.

Provisions for medical review, standing orders, consultation, clinical record, transfer procedures, management policies, drug dispensing, and utilization review are very appropriate factors to be addressed.

And I would say, Mr. Chairman, that most of the clinics that I have described in New Mexico would comply with these require-

ments

Hopefully, the regulations would not be as restrictive as some of

the medicare regulations we have had for our rural hospitals.

We are concerned about the issue of payment for physician extender services, or the method of payment. We have a tremendous amount of information that is required for cost reimbursement. In most instances, the rural clinic would have very little expertise in accounting. As a matter of fact, a lot of them are community based and developed, and would not be able to meet the demands for all of this fiscal data.

We would urge some sort of simple system, like a per-visit payment; a simple billing procedure can be developed without requiring that they hire an army of accountants to prepare these cost

reports.

In addition to that, under the cost reimbursement formula, there is the problem of retroactive settlements, which could be devasta-

ting fiscally to the cash flow.

Regarding the definition of physician extenders, the certification appears to be somewhat restrictive. It is our understanding that only 700 nurse practitioners in the country have taken the national certification exam. This represents somewhere between 10 and 20 percent of the nurse practitioners in the country, depending on whose figures you use.

Most States have developed certification of nurse practitioners and physician assistants through nursing boards, medical practice

boards, or combinations thereof.

Senator Leahy. Excuse me. On the number who have taken the national certification examination, do you know if that is because of the lack of facilities or areas calling for nurse practitioners, or is it because of the way the exam itself is set up, or is it because the State, the individual States' certification procedures have proved adequate, or a combination of all three?

Mr. Mondragon. I think it is a combination of things. I would just say, No. 1, that there has only been one round of exams given—

and there is one coming up pretty soon, is my understanding.

Second: Particularly in rural areas, the nurse practitioners who are working independently usually do not have any backup, and they have a problem getting away for the review sessions, and they also have a problem getting away for actually taking the test, over a 1- or 2-day period. So it is a combination of factors.

The other thing is that they are usually held in concentrated areas. In New Mexico, they were held in Albuquerque and transportation, in effect, takes the person away from their health care de-

livery setting for 2 or 3 days.

Senator Leahy. New Mexico is a big State.

Mr. Mondragon. It is.

Again, we would hope that if such local examination are determined by the Secretary of HEW to be equivalent to the national certification exam that they be accepted by medicare in place of national certification.

I think, again, this is consistent with the present medicare law, which calls for local or State boards and agencies to determine credentials, instead of some sort of national policy or national

credentialing system.

In summary, we strongly support bill S. 708, essentially in its present form, and would only urge flexibility in the matter of reimbursement methods and also in the certification of physician ex-

tenders.

One other thing, and that is the definition of "medically underserved." In some cases, even though numerically there may be enough physicians in a rural area, there is the problem that was mentioned this morning of some physicians not seeing medicare patients, or some physicians not seeing medicaid patients, because of the fact that they are very busy and, secondly, because of the paperwork involved with these patients.

Thank you very much. I would be glad to answer questions. Senator Leahy. Thank you very much.

Dr. Edgar Beddingfield, the chairman of the council on legislation of the AMA.

STATEMENT OF EDGAR T. BEDDINGFIELD, JR., M.D., CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION. ACCOMPANIED BY HENRY N. PETERSON, DIRECTOR, DEPART-MENT OF LEGISLATION

Dr. Beddingfield. Thank you, Mr. Chairman.

I am Dr. Ed Beddingfield, a family practitioner, from Wilson, N.C., and I serve as chairman of the council on legislation of the American Medical Association.

With me is Mr. Harry Peterson, who is the director of our de-

partment of legislation.

Mr. Chairman, I would like to amplify a bit on my own introduction because, in addition to being a spokesman for our professional organization, I also speak from a background of experience in rural practice and experience with the provision extender programs, having been on the advisory group of Duke University when the physician assistant program was first created there, having been involved in the training at two universities of nurse practitioners, and having been the supervising physician of a rural satellite clinic for 4 years, manned by nurse practitioners. So I speak from that background, as well as from that of my organization, for whom I speak.

Basically, being consistent with your mandate about time, I would simply say that we are in favor of better health care, we are in favor of rural people, we are in favor of old people, we are in favor of judicious and supervised use of physician extenders, and we are in favor of payment under medicare for services of physician extenders.

With that background out of the way, I will tell you what

bothers us about the bill.

There are certain things about the bill that do bother us, and I would simply highlight these, and you can question me about them, but we do go into detail in our printed testimony here.*
Senator Leahy. Which will be part of the overall record.

Dr. Beddingfield. Thank you very much.

Senator Leahy. We are pleased in the definition of "physician extender" to see that you do defer to the jurisdiction of the States under their various licensure acts.

Dr. Beddingfield. We do feel that there are some technical points. which we touch on page 3 of our testimony, which are a little ambiguous, and we are not certain exactly how the bill, if enacted,

would apply to the definitions that the various States have.

And we are pleased to see the later provision that the bill does not supersede State law. But when it describes the various services that a physician extender might do, it gets a little hazy, and we

speak specifically to that.

To the point of construction clarification, we believe that the deficiencies which we recognize in this area could be overcome by clearly stating that the services of a physician extender would be recognized only to the extent that the extender is legally authorized to perform such services in the jurisdiction in which such services are provided.

Senator Leahy. Do you see that as a State certification, rather

than a national one?

Dr. Beddingfield. I think that the requirement for certification should be left up to the State. I think the prime responsibility ought to be with the State.

For example, in-

Senator Leahy. I understand that a large number of States now

just use the national-

Dr. Beddingfield. Then that should be their prerogative, just as in medical licensure, many State boards of medical examiners use the national FLEX examination; other States might prefer to develop and administer and grade and score their own tests. That should be a prerogative of the State.

Senator Leahy. You would leave the national test in place, so

that if States want to use that, they can-

Dr. Beddingfield. Yes.

Senator Leahy [continuing]. But that the individual State, whether it is North Carolina, or Vermont, would be determined by whatever North Carolina decided or Vermont decided?

Dr. Beddingfield. Yes, sir. We do believe that is a prerogative of

the State.

We have some concern with the definition which we just touched on about the accrediting agencies. I will not dwell on that.

We have a particular concern with the term, "rural health clinic services." We do not believe there appears to be a sufficient limita-

^{*} See p. 181 for the prepared statement of Dr. Beddingfield.

tion on what might constitute a rural health clinic service, since the requirement in the bill is only that such services be furnished by physician extenders.

We are troubled by the term, "primary care patient."

Senator Leahy. Let us take the rural health care clinic part.

What would you suggest we write in there?

Dr. Beddingfield. Well, I think that my final recommendation as to what you ought to do with the bill will answer that question, if I may proceed, sir.

Senator Leahy. Go right ahead.

Dr. Beddingfield. We think, when you use the term "primary care patient," the scope of medical care encompassed in the term. "primary care," has not been universally defined, and certainly not in the statute, and accordingly, the term would introduce many problems relating to coverage and eligibility.

Now, one of our principal concerns is the creation of a new and heretofore undefined entity, called a rural health clinic. And only if services under medicare, delivered by a physician extender, were

delivered in such a setting would they be reimbursable.

We feel that this is unnecessary, and that you could solve the whole situation simply by amending the Social Security Act to say the Social Security Act will pay for services of physician extenders when they are rendered under certain basic sets of conditions, which we will suggest to you.

Senator Leahy. The Social Security Act or the Medicare Act?

Dr. Beddingfield. I believe that medicare is part of the Social Security Act.

Senator LEAHY. Yes.

Dr. Beddingfield. Therefore, we have trouble with many of the definitions. We have trouble with the new type of structure. We are concerned by the fact that the initial thrust of the physician extender movement was to be a direct extension of the physicians' capabilities.

For example, I use a physician extender, in my office, working with me. I supervise, at a clinic 17 miles away, a family nurse

practitioner, who is seeing patients.

Under this bill, the one at the remote setting would be paid. The one who is working and who is directly supervised by me would not be paid. I think that is clearly and flagrantly discriminatory, when vou have similar old people, 17 miles apart, going to one facility or the other.

We believe that if the medicare program is to recognize payment for services of the physician extenders, that this discrimination to which I speak should not be created against the basic situation out

of which the extender concept developed.

The basic concepts—and we think these are important—we feel must include: First: Proper supervision and control by the physician of a properly trained physician extender. We do not believe in the concept of independent physician extenders. We believe they should be dependent and supervised.

Second: We believe in the responsibility of the physician for the services, as evidenced by the billing for the services in the name of

the physician. Third: Compliance with State requirements.

If these are adhered to, the use of physician assistants would be

encouraged in shortage areas.

We would agree with the plight that has been described, of many of the rural clinics that we have heard in testimony this morning, that reimbursement means survival or nonsurvival for many of these clinics. The same situation is true in North Carolina as you have described in New Mexico.

To this end, we believe that a simple amendment to the medicare law, giving recognition to the true nature of the extender services, would be more appropriate than creating the medicare-defined rural

health clinic, in order to recognize extender service.

Accordingly, a simple amendment, to include the extender service as an integral part of the physician service would foster the development of the original concept and help provide quality care in rural areas.

We are in favor of the concept, but, Mr. Chairman, we believe

that S. 708 as presently written should not be adopted.

I will end my summary remarks there and try to respond to your

questions.

Senator Leahy. Would your membership pay for the option of reimbursement for clinics if a physician extender were employed

by a community clinic and not by a particular physician?

Dr. Beddingfield. Under our State law and under the laws of most States, there is a requirement, not of employment, but of direct responsibility. You cannot become a physician extender or a nurse practitioner in North Carolina or in most States, and be approved for practice, unless there is an assigned, one-to-one relationship. A corporate entity such as a clinic could not hire a physician assistant.

Senator Leahy. Is that supervision, or is that employment?

Dr. Beddingfield. Well, it is supervision. It does not mandate

employment.

Senator Leahy. But for example, if the clinic went out and hired the physician extenders—and assuming that there is a requirement of supervision under their State law—and then they may go and hire a physician for that supervisory role, would you have any problems with reimbursement directly to the clinic—insofar as the extender was not hired by the physician; rather the physician was hired to supervise the extender, who is also hired by the clinic.

Dr. Beddingfield. Yes. I would continue to have some problem with that, but I think in light of my own personal experience, there is a way around it. I believe that you maintain control by maintaining control of the money. For example, what would happen, in such a setting as the scenario that you paint, if the physician died, or left town, or lost his license, or whatever, and the physician extender was still an employee of the corporate, quote, "rural health clinic"?

Senator Leahy. Don't you have basically the possibility of that

same problem, anyway?

Dr. Beddingfield. No, sir.

Senator Leahy. If you have a physician who hires a physician extender, who goes and works in that particular clinic, people become dependent, not only medically but socially. Whereas, if the

additional physician dies, the physician extender may still continue on, even though you have to bring a different physician to

supervise.

Dr. Beddingfield. Legally, in most States, and most certainly, in North Carolina, his approval for practice would terminate with the death of his initial sponsoring physician, and he would have to go through the process again, to be approved for practice with a different physician.

He would have to appear again before the State board of medical

examiners, and a job description submitted.

Senator Leahy. Yes, but our bill does not change that, whether

the clinic hired him or not.

Dr. Beddingfield. Well, to get back to your question, would I be bothered by reimbursement going to the clinic, yes, sir. I would prefer that the reimbursement go to the physician who is legally responsible for the acts of this particular physician assistant.

Now, if that physician wishes to assign payment under this plan to the clinic, then that is his prerogative, because he can then cancel that at any time. As a matter of fact, this is what I personally do under medicaid right now; in our State medicaid does pay for the services of physician extenders. I do not get the checks. They go to the clinic because I have assigned them to the clinic.

But if the activities of the people for whom I am legally responsible did not meet with my approval as I reviewed their charts, as

I supervised their work, I could terminate that.

Senator Leahy. Can we avoid a medicare mill type problem if physicians are reimbursed for extender services, especially if this bill goes into urban areas, where there are large concentrations of elderly people?

Dr. Beddingfield. Well, I can certainly forsee the difficulties. I can forsee even a magnification of difficulties that you have with-

out extenders being paid under medicare.

However, we testified just last week on the medicaid mill proposition, over on the House side, and I believe that some of the machinery has already been set in motion. Fraud is against the law, and fraudulent people ought to be indicted and hauled into court. And I think that there are ample mechanisms or tools for doing it.

The Attorney General felt the same way.

Senator Leahy. As a former prosecutor, I believe very strongly in prosecuting people if they have violated the law, and I have prosecuted a number of my own brethren on the bar, on criminal matters. I also prosecuted some members of the medical profession, although I found it extremely difficult to get members of the medical profession to testify publicly, even though they have done it privately, that certain criminal activities are taking place. The same thing happens in the legal profession, I want to add.

But don't we want to make sure we tie up a bill in such a way that we preclude as much as possible even the possibility of crimes

occuring in the first place?

Dr. Beddingfield. Of course you would. May I ask you this, sir. You asked me a question, if this payment mechanism were to become operative in an urban area, would it not lead to a medicaid mill-type operation. I do not think there is anything that would

of necessity preclude this in a rural-type setting. I think the same dangers-

Senator Leahy. Concentration of people, I think, is what bothers

us more than anything else.

Dr. Beddingfield. In other words, it is fraud if you rip off \$10,000, but it is not fraud if you just rip off \$100.
Senator Leahy. That is not what I am saying. I am just saying

that the potential for it is greater.

Doctor, would your practice not qualify as a clinic under this bill?

Dr. Beddingfield. My individual practice? No, sir. I am in a large group practice, in the city of Wilson, N.C. I have 22 phy-

sicians in association with me.

However, as the doctor from Iowa told you this morning, initially, I did do solo family practice, for a period of 17 years, and I have been in this group practice, over at the county seat for the last 10 years.

Senator Leahy. You went from one extreme to the other.

Dr. Beddingfield. Only 10 miles away, though, those particular two. And in association with some of my partners in the group practice, we helped to develop and now supervise a remote facility, which I described, manned by nurse practitioners. That is over at Walstenberg, N.C., which is in Greene County, and much has been written about the Walstenberg clinic.

Senator Leahy. Thank you.

Our next witness is Anne Zimmerman, who is president of the American Nurses' Association, R.N., who has written to me and to the committee regarding S. 708.

Again, we will put Ms. Zimmerman's testimony in the record, the

prepared testimony in total. Go ahead.*

STATEMENT OF ANNE ZIMMERMAN, PRESIDENT, AMERICAN NURSES' ASSOCIATION

Ms. ZIMMERMAN. I really have a few comments that I would like to make, and I have departed entirely from the testimony, which will be a part of the record, and does make the kinds of recommendations that we feel are important.

I do want to emphasize that along with the previous testifier, we believe in all of those things. We even believe in doctors, as well.

And I think that it is important legislation—

Senator Leahy. My wife who is a registered nurse and a member of the American Nurses' Association also does, too, so it goes right down through all the rank and file.

Ms. ZIMMERMAN. Good for all of us.

I do believe, as I represent the American Nurses' Association here, that this legislation will include access to primary health care and will not dilute the standard of care where people live.

I think there are a few things that are very important for me to say with regard to three major parts of the bill.

In your statement it would be important to know who you are reimbursing, rather than the current title, so I would say, then, re-

^{*}See p. 185 for the prepared statement of Ms. Zimmerman.

imburse the nurse and the physician extender—which also includes

the physician assistant—so that it is very understandable.

This is a very well-known designation. Registered nurses in this country have a common base of licensure. They take the same State board examination all over the United States. And you know al-

ready that this kind of mobility is extremely important.

We believe that nurses have a designation that is recognized, it is understood everywhere, that the practice of a nurse is not dependent on another professional. And therefore, to say that a nurse is an extender of a physician, or a physician extender, is incorrect, in terms of the independent license under which she practices, the accountability that she has for her practice, the accountability she has for patient care, and the fact that she carries her own malpractice insurance.

The term physician extender, we all know, was designed by the people who were desirous of expediting a phrase that would be umbrella-type, but not necessarily one that has any particular mean-

ing.

I therefore do not believe that changing the bill to provide reimbursement for services provided by nurse practitioners or nurse clinicians or clinical nurse specialists and physician extenders, which would include physician assistants, would in any way interfere with or do anything of violence to the idea of reimbursement for services in rural health clinics.

I also believe that where differences have been expressed, as they have here today, by nurse practitioners, as to whether or not they would object to the words, physician extender, it is more an acquiescence to the term than it is an embracing of the term as an

identifying area of practice.

Senator Leahy. You realize, of course, that in introducing the bill, Senator Clark said that the bill uses the term physician extender to signify the types of primary health providers who work in rural health clinics, and what is currently the most generally used term and we ought to explore other possible ways to clearly denote the concept of a primary health practitioner.

Ms. ZIMMERMAN. Right.

Senator Leahy. Something very similar to the statements that I have also made. As we are the two primary sponsors of the legislation, we are not emphasizing that the term itself, we are certainly not hung up on it, we are far more interested in the particular concept, and particularly, what it is that we want to get in the way of medical services into rural areas.

Ms. ZIMMERMAN. Again, we are committed to the tradition of health services, because we believe that health services for patients, for people, for clients encompasses a great deal more, really, than just medical services. And for this reason, we do believe that the connotation of primary health care practitioner is a very acceptable

one.

There are differences between the nurse practitioner and the physician assistant, and I think that you already have those and will be described by the physician assistant representative.

In relation to the word, "supervision," as this word is now described in the bill, it really is not relevant, I think, to what it is

you are trying to get at in terms of reimbursement for services. It is too stringent, and it does not allow what the bill is intended to do.

The nurse practitioners work with doctors, in consultation with them, in collaboration with them, in the referral systems with them. Many patients would not see doctors if they were not referred there by nurse practitioners.

But there is no way, I believe, that the medical profession can supervise all the health care which this Nation needs, and which

everyone is trying to provide.

I believe that if the word "supervision" as it applies to registered nurses were changed to "consultation" or "collaboration," that it would augment the opportunities that are provided in this bill

for the delivery of services.

Senator Leahy. Does that work also in the development of protocols? I mean, the protocols would not be developed by the physicians; they would be developed only in consultation with nurse practitioners and quite possibly, if there was a disagreement, the protocol may end up being developed by the nurse practitioner, and not by the doctor.

Ms. ZIMMERMAN. I think that a protocol is something that is developed between the people or among the people who are working together to decide what the regimes will be, and under which

they will function.

Senator Leahy. You realize that in our bill, we speak of supervision by medical doctors of medical services only.

Ms. ZIMMERMAN. Yes.

Senator Leahy. And not of nursing services.

Ms. Zimmerman. Yes. But what nurses do as part of their new role becomes nursing service. There is a medical regimen carried out by the physician and a nursing regimen without medical consultation which is carried out by the nurse and these do not conflict. There is an overlapping area where the nurse works within guidelines and medical prescriptions and consultation to provide certain health care services that can also be provided by a physician.

Senator Leahy. Do you see some problems in various States when they set up different licensing procedures for M.D.'s, other licensing procedures for R.N.'s and so forth, if they feel there will not be supervision by M.D.'s of medical services, but only consultations? Would there be really any need—in that instance, would there be any need to set any different standards for M.D.'s than

Ms. ZIMMERMAN. Yes, I think there would be, and I think there

are varying ways in which State laws are handling this now.

I think one was described by the representative of the AMA from North Carolina, and there are other ways in which things are being done. They are being done between the board of medicine and the board of nursing, where the protocols are designed and put together by those two groups, working together, to decide what they shall be, and the nurse practitioner working under that set of protocols, does that with whatever medical backup, or collaboration, is provided for in the protocol.

Senator Leahy. But there would be some medical supervision at

some point?

Ms. ZIMMERMAN. I think it depends on the use of the word; what do you mean by supervision? The nurse is responsible for her/his own actions.

Senator Leahy. Well, what do you mean by it? I do not seem to understand, because as I hear this, I am not sure why we should have any different registration standards for an M.D. or a nurse

practitioner.

Ms. ZIMMERMAN. We know that the licensure laws for the various States have differing definitions for the practice of medicine as well as they do for the practice of nursing. They are more uniform, it is my understanding, for the practice of medicine, and much broader, than they are for the practice of nursing.

There are many States—and I have the documentation, if you

would like to have it-where, within the State laws, it does prescribe the kinds of things where there are overlapping or congruent functions between medicine and nursing, where these are examined and determined as to who does what, and those things that are considered to be only the practice of medicine, and those things which can be considered to be done by both doctors and nurses are so described in the protocol, with the input of the doctor at the time the protocol is arrived at.

Senator Leahy. So you do not accept the fact that there may be certain things that a nurse practitioner could do, beyond what she or he would normally do, if we add the additional element of an M.D. supervision? Are you saying that a nurse practitioner could reach a certain level and then beyond that level only she cannot step beyond that, no matter what skills he or she has acquired, and that there is not another plateau where additional skills can be

used, provided there is supervision from a medical doctor?

Ms. ZIMMERMAN. It is my opinion that those things that the nurse does which need the consultation of the doctor are not necessarily

on one level or another.

There may be times at which the condition of the patient will allow the nurse to do certain things, because of the protocols that have been described. In her judgment, the patient's condition would need a doctor's attention and would disallow her doing that in another circumstance.

So I think to say that she can do this in this case and not do it in

another case oversimplifies what it is that nurse can do.

Senator Leahy. But you do not see any area in there where there are certain things that she can do that she would not do on her own,

but could do with medical supervision?

Ms. ZIMMERMAN. That is right, but it's medical collaboration, or medical consultation, or medical referral, or whatever you want to call that word. She has joint practice; nurses and doctors giving patient care together. And I do believe that that kind of collaboration has to occur.

Senator Leahy. Please continue. You must realize I am just a country lawyer, and I have to kind of wade my way through this

and try to understand it.

Ms. ZIMMERMAN. Well, I think one's head gets so full of rebuttals by this time of day that you cannot always sort all of them out in the way in which you had wanted to present them when you first came in.

Regarding-may I comment just about the standards, because

this has been referred to here. Senator LEAHY. Certainly.

Ms. ZIMMERMAN. I believe that there do need to be standards, and we have suggested that the certification of the American Nurses' Association of the various practitioner programs is one way to go.

I realize that this is a new kind of certification, that it may be in the future. But I do think that we do not want any kind of care provided in the rural clinics and reimbursed by the Federal Government to be considered second class, simply because there are not some kinds of standards that are available, peer review and other-

I think that is all that I really need to say, in light of the state-

ment and your questions.

Senator Leahy. Thank you very much.
Mr. Fox is the physician assistant, president-elect of the American Academy of Physician Assistants.

Mr. Fox?

STATEMENT OF DAN FOX, PHYSICIAN ASSISTANT, PRESIDENT-ELECT, AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, ARLINGTON, VA.

Mr. Fox. Thank you, Mr. Chairman. I will be brief, and I will address most of my comments specifically to the bill, in terms of our concerns.

Allow me to interject a couple of points. One, the Academy, which I represent, shares the concern of the Congress over rapidly increasing health care costs and also over the fraud that has been detected in the medicare/medicaid system.

We also share concern and commitment to the provision of accessible, low-cost, high-quality health care to the aged and medical-

ly deprived populations in rural and in urban America.

In our written testimony, which I understand will be part of the record*-

Senator Leahy. Yes, it will.

Mr. Fox. We did make specific comments and references concerning the education and certification of the physician assistants in the United States, and I would like to make specific mention of that, not to reiterate it, but just to point out that it is in fact there, and to mention two things. One, we have a very valid and ongoing accreditation mechanism for the PA programs in the United States, which is conducted by the American Medical Association, in conjunction with the related medical specialty organizations and our Academy.

And we believe very highly that that is a valid and proper way

to go in terms of accreditation of programs.

^{*}See p. 191 for the prepared statement of Mr. Fox.

Second, we have a certification mechanism that is national in scope, that was developed by the National Board of Medical Examiners, and is now administered by the National Commission on Certification of Physician Assistants, an organization unique in that business. The Commission is composed of representatives from 14 separate organizations and concerned public citizens, who control—exercise control—over that specific examination.

So we think very highly of those accomplishments. I might add that the National Board of Medical Examiners is making a validity study of the certifying examination, and early results have indicated that it is a highly reliable and valid examination, one which

we are proud of.

One other comment, and then I will just refer specifically to the bill. Over our short, but, I think, significant history of the P.A. profession being in existence, we have seen the placement and the employment of P.A.'s in primary care settings throughout the United States. I think this initiative is due to the program directors and the people that we recruit into the programs. They are very interested in, and we recruit people who are oriented to rural areas. Many of our programs have outreach activities where the students spend a great deal of their time in rural areas. That has been successful and we have seen a high rate of P.A.'s going into the rural and medically underserved areas of the country. Therefore, we are very proud of that history as well, and I wanted to

point that out.

We endorse bill 708, with a few recommendations. We are very concerned that the way the bill is written currently, it would preclude reimbursement to primary care physicians who are providing a very needed service already in rural parts of America. We hear it would preclude reimbursement for them, since it has a clinic structure defined into it, and since there is some question that they would not be eligible for reimbursement under that clinic structure. This is a big concern, and we have suggested in our written testimony a way we think, of handling that; although based upon my knowledge of your comments earlier, it may not be exactly what you had hoped for. We believe that bill 708 is fine as written in reference to rural health clinics, but should be expanded to include reimbursement to supervising physicians for services rendered by physician assistants, at the usual and customary rates of reimbursement for those practices that are located in medically underserved areas. This action would address the issue outside of the rural health clinics per se. And we would like to go on and recommend that some mechanism of reasonable and appropriate rates of reimbursement be developed for reimbursement of physician assistant services to physicians in all other practice locations.

Our second and final area of concern in the bill revolves around

Our second and final area of concern in the bill revolves around the definition of supervision. The American Academy strongly encourages the insertion of the words, "responsible supervision"

throughout the bill, where appropriate.

We recognize the role of the P.A. as a dependent practitioner, functioning under the responsible supervision of a physician. We would encourage, however, that the terms, "physical presence," or

any terms that would infer that, not be included; but the there be clearly established an ongoing, supervisory relationship with the physician.

I think that I will end the testimony there. Thank you very

much. I would be happy to answer questions.

Senator Leahy. What is responsible supervision, and does it clash with Ms. Zimmerman's idea of consultation versus supervision?

Mr. Fox. I would not use the term, "consultation," as such. Responsible supervision implies—I do not have any specific wording at hand—but I think it implies an ongoing relationship between the physician and the P.A., so that the physician is aware of the care being rendered, whether or not he is personally overseeing it.

Senator Leahy. Dr. Beddingfield, would you accept the term, "consultation," except in States where more stringent supervision

is required?

Dr. Beddingfield. I would like to answer that this way, sir. I believe that when nurses are practicing nursing, they are professionals in their own right, and they do make independent judgments. I believe that as the role of the nurse begins to expand, and nurses begin to do things that were traditionally done by doctors, and for which a doctor is responsible, I believe the proper word is "supervision," and I would insist on that.

I think that at that point, the nurse is, in fact, an extension of the responsible physician, whether she admits it or not, and he is

the person—that is where the buck stops.

Senator Leahy. Ms. Zimmerman, would you like to respond to that at all—you are probably going to get the chance to be the last word in the hearing today. Go ahead.

Ms. ZIMMERMAN. You really couldn't do me better.

I think that there is a page of what we mean by supervision in our testimony, and whole variety of definitions of supervision.

And I believe here again that it is those roles that are overlapping. We do not believe the nurse practices medicine. She is not a doctor; she is a nurse.

If there are areas of overlap between the two, that is the area where the doctor and the nurse determine what that nurse is going to do in consultation with her, and what the patient's needs are.

Senator Leahy. But you would not accept the fact that there may be areas that a nurse would go beyond that with his or her skills,

provided there is physician supervision?

Ms. ZIMMERMAN. Yes; I would agree, that yes, she can do that. And since I do have the last word, there are so many things that people living in the rural areas need—such as teaching, such as all kinds of support services—that really fall far short of exotic medical care, that I think this is what the goal of reimbursement is for those people.

Senator Leahy. I thank you all very much. We have kept you here longer than you were told you were going to. I can only say that I thank you, and the Senate thanks you, and I do not just mean that as idle words. This is a bill that is extremely important to this committee, not only the subcommittee, but to the whole committee. I suspect we are going to have over 51 Senators as co-

sponsors of it within a week. It is an extraordinary rare thing that

that happens.

I think it expresses the concern of not only Senator Clark and myself as the prime sponsors, but of the whole Senate—Republicans, Democrats, conservatives, liberals, moderates—all parts of the country are represented.

You have done yeoman's service—maybe we should say yeoperson's service—to us here in testifying. If any of you think of further things that you want added, or if you start thinking of additional matters that you want added, do not hesitate. We will keep

the record open a week or so for that purpose.

I thank you very much.

[Whereupon, at 3:10 p.m., the subcommittee adjourned, subject to call of the Chair.]

ADDITIONAL ARTICLES, LETTERS, STATEMENTS, AND MATERIAL

STATEMENT OF HON, DICK CLARK, A U.S. SENATOR FROM IOWA

I'd like to welcome all of you to the Senate Rural Development Subcommittee's hearing on rural health clinics. This Washington hearing follows two sets of hearings conducted in Vermont and Iowa last year by Senator Leahy and me. While those hearings were situated in two different parts of the country, they had a common thread—they revealed a persistent obstacle to health services in small towns and rural areas.

The obstacle I'm referring to is a particular Medicare policy that prohibits payment for care provided by nurse practitioners and physician assistants. unless a physician is present. Nurse practitioners and physician assistants are a relatively new group of health professionals who have been specially trained to provide basic and emergency health care. Health clinics across the country use their services precisely because the areas have lost their physicians.

The 32 million rural medically underserved Americans therefore find themselves in a double bind situation which must be corrected: Because of a lack of physicians they must rely on physician extender care, but that care cannot

be reimbursed if no physician is present.

Furthermore, the Medicare policy clearly conflicts with other federal health priorities. On the one hand, we are trying to curb the spiraling costs of health care. Yet, at the same time, we are forcing small town and farm residents to travel many miles to a large city in order to get reimbursable health services, because that's where the physicians and hospitals are located. And while we spend millons of dollars to educate and train nurse practitioners and physician assistants, we perpetuate a Medicare policy that effectively curtails the utilization of those health professionals.

In preparation for this hearing, I requested assistance from the Department of Health, Education and Welfare to give us a better understanding of the

nature of the problem.

The Social Security Administration provided us with data that underscores the extent to which Medicare discriminates against rural Americans. I am submitting for the record a chart that shows that residents of urban states are receiving—on the average—two to three times the amount of Medicare

benefits residents of rural states are receiving.

Information from the Bureau of Community Health Services tells us that the Medicare policy serves to magnify an existing crisis situation in America's small towns. More than 30 million people live in rural areas which HEW has designated as medically underserved. This number represents one third of the nation's rural residents. The problem is even worse among those who benefit from the Medicare program—the elderly. Forty percent of the rural elderly, amounting to 3.6 million older Americans, live in medically underserved areas.

Finally, the National Center for Health Services Research has compiled a body of valuable information about state policies and research findings on physician assistants and nurse practitioners. The report contains two major findings:—42 states have legislation pertaining to physician assistants and 29 states have indicated an expanded role for nurse practitioners; —26 states allow Medicaid reimbursement for physician assistant services and 18 states allow Medicaid reimbursement for nurse practitioner services.

Together, this information illustrates the magnitude of the inequity in the

Medicare program. Today, we are here to listen to those who have first-hand knowledge about this problem. We will receive testimony from small town residents, clinic directors, nurse practitioners, physician assistants, rural physicians, and experts in the field of health care delivery, in addition to representatives from the Department of Health, Education and Welfare and from

various health professional organizations.

Most of the testimony today will be focused upon S.708, a bill which Senator Leahy and I introduced this session to allow Medicare reimbursement for rural health clinic services. S.708 now has 44 cosponsors, so it has substantial

support from members of the Senate.

The key elements of the bill are the following: First, the clinic itself, rather than any particular provider within the clinic, would be reimbursed for primary health care services; Second, the reimbursement would be based upon the costs (rather than charges) of providing those services; Third, while S.708 does not require the continual presence of a physician at the clinic, it does allow reimbursement to clinics where physicians and the other primary health practitioners are simultaneously providing care; and Fourth, the clinic must serve a rural, medically underserved population.

The bill also requires the clinic to meet certain criteria in order to receive Medicare reimbursement, relating to physician consultation and referral, clinic records, hospital referral and management policies. In addition, the bill would define "physician extender" as an individual who is certified as a physician assistant by the National Commission on Certification of Physician Assistants or as a nurse practitioner by the American Nurses' Association.

I want to emphasize the importance of this subject for the nation's health policy in general. Countless Congressional reports and hearings, executive department studies and academic studies have dealt with the topic of making primary health care accessible to areas that lack physicians. I believe, and I predict today's testimony will underscore this point, that there are literally thousands of communities, located in every state, which are growing increasingly discouraged as they continue to wait for a doctor to settle in their areas. They do not perceive clinics staffed by nurse practitioners or physician assistants as inferior care. Instead, they view these clinics as the last, best hope for their communities. I hope Congress responds to those millions of medically underserved Americans, who justifiably feel that they deserve the same Medicare benefits as medically fortunate Americans.

A change in Medicare's policy would surely influence many states and private health insurers to re-examine their own policies in this area. Therefore, I believe that legislation along the lines of S.708 would have far-reaching benefits for all Americans, be they young or old, or rural or urban residents.

STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM VERMONT

Mr. Chairman, a little over a year ago this subcommittee held field hearings in my home State of Vermont. At these hearings we looked at some of the ways small rural communities were attempting to cope with the most serious health care problem facing rural America—the shortage of primary health

care personnel.

We discovered that many of those areas which lack physician's services have come to rely on local clinics for their primary health care needs. These clinics are staffed by specially trained health professionals called nurse practitioners who are able to diagnose and treat primary and emergency health care needs. Physicians in nearby communities provide both backup and audit services.

The organization of the clinics is as diverse as the communities they serve. But, one factor is central to all successful efforts: community support and commitment to the clinic. At the hearings in Grand Isle, Vermont, there were about 100 users of the health clinic present who attested to this community

Mr. Chairman, I would like to insert into today's hearing record the testimony given in Grand Isle which clearly demonstrates the community support

to their health clinic.

I think there is a lesson here to be learned. I have serious doubts whether we in Washington can design or impose any health care system in any community in this nation if that commitment and support does not exist at the local level.

However, we must do everything within our power to remove any barriers which hinder the viability of these much needed clinics.

I am very pleased, therefore, to join you in sponsoring S.708, which would break down a barrier created by current Medicare policy. At present, Medicare will reimburse for services performed by non-physician health personnel

only if these services are performed in the presence of a doctor.

This regulation puts rural clinics in a Catch-22 situation: for example, in Grand Isle, Vermont, nurse practitioners are used because there are no doctors, but there must be a doctor present if the nurse practitioner is to be reimbursed. Clearly, this discrimination compounds the already massive health care problems of rural America.

I am hopeful that the passage of this measure will help alleviate one of the problems faced by these clinics: long-term financing. Currently, funds may come from many sources, most of which are short-term or undependable. By providing reimbursement of these clinics on a costs incurred basis, we will literally be throwing a life-line to thousands of people in rural America.

The following material was furnished by Senator Leahy and referred to on p. 10.]

STATEMENT OF BARBARA ABARE, PRESIDENT, GRAND ISLE COUNTY HEALTH COUNCIL, INC., GRAND ISLE, VT.

Mrs. Abare. I think I was asked to briefly capsulize and tell you a little of the history of the health council, and as I look around I see some of those famous nine angry women and I'm beginning to hope that we are living that reputation down. But the health council was started nearly 4 years ago when a group of us became upset and quite tired of the amount of money that was being spent in the county to do studies. At the time we had formed the health council there was another study going on which was to help the people of Grand Isle County to appraise their health situation, and in this study \$40,000 was spent. And I guess to date there isn't even any written report on this study. To make a long story short we met up in North Hero at the school and we formed a health council and from that time to the present we have kept really quite busy. We have had several gentlemen work on the council with us. We have could represent from each town and a country member. with us. We have equal representation from each town and a county member at large. In the membership of our health council are five, at the present time, women who are serving on the board of the VNA in Burlington. This is the Visiting Nurse Association, and it was because of our close association with the VNA and the fact that Sue Heath, the nurse practitioner, pediatric nurse practitioner was in the county with the mobile unit and traveling from one end of the county each year that we sat down and talked over the health needs of Grand Isle County. And with Betsy Davis' help our first grant through HEW was written and the Champlain Islands Health Center came into being. And while we always say this health center is in a trailer it's a little hard to identify it strictly as a trailer, but we, as I said, we are women who believe in trying to get out and doing something. So one of our members picked up a Mash field hospital, which we unpacked. People donated everything that we could think of. Even our home demonstration group became involved and gave us a shower of household items because actually we had no cash locally to set up this health center. And it will be 2 years this April that we started our first screening physical examination and 2 years this May that we opened, and I do not have the figures right down to the most current, but I do know that at one point we had had 2,800 patient visits and of this number there were approximately 56 who had to be referred on into Burlington or St. Albans for further follow up.

I'd like to take just a moment if I could. I think there are people here who don't know who the health council members are and who they can turn to in their own community if they have questions, so if I may ask the council people as I introduce them to please stand up. From Isle LaMotte there is Mrs.

Hill, Edith Hill. Thank you, Edith.

Senator Leahy. I might just put in one personal note which will probably boggle the people when they read the record, but Mrs. Hill is a former neighbor of mine in Burlington, Vt. In fact, we lived in a duplex house. We lived in one side and Mrs. Hill was on the other, and she is a long time friend and I'm not the least bit surprised to see that she's actively involved in this.

Mrs. Abare. And from Alburg we have Nancy Christopher. Nancy is also health officer up there. And Anna Bohannon who is the lady that said nine angry women started the health council, and it will take an army to stop us. And also Reba Schumway from Alburg. And from North Hero is Alice Blackwell who's been with us from the start and Margaret Whittlesley. And I guess I'm the only member from Grand Isle present, and from South Hero, Marsha Frechette and Barb Duffy, and Ethyln Dubuque. And I guess one of our other members is at play practice and hasn't got away yet.

Senator Leahy. I should probably add for the committee that the chairman

of this hearing is personally acquainted with just about everybody here

tonight.

Mrs. Abare. So this was the health council group that worked together to start the health center and then we have been very very fortunate to havewell, I guess let me backtrack just a minute. Before we started the health council we asked Betsy Davis if the nurse who was employed in the VNA home health nursing program could be an island resident, and out of retirement came Audrey Noel and Audrey is the VNA nurse assigned to the island. Then when the center, we began to discuss the center formation more fully, we were very happy, and I say this with a great deal of pride, that Sue Heath asked to come back, and I'm sure there's many days that she may wish she wasn't here, but for 2 years she's run up and down the county and Sue is our pediatric nurse practitioner at the health center. And we have been very very fortunate to have Dr. Fred Holmes from St. Albans who serves as Suc's pediatric backup physician and pediatrician, and Dr. Alan Rubin who started out in the beginning with us from Burlington, and now is medical backup physician and medical onsite physician.

And, of course, again I say this proudly, and I know we all wear many hats, but this couldn't have been accomplished, we couldn't have had this health center if it hadn't been, and I'm going to use the words, many hundreds of hours, of Betsy Davis, the executive director of VNA has given to us and we

thank you again, Betsy.

Senator Leahy. For the record, might I just inject a question. This was a case, I take it from what you have said here, where all of the community were actively involved and it was not a case where the Federal Government suddenly came into the program with a great deal of money and a whole lot of people to do the work, but it's the communities themselves and the people

in them that put the program together.

Mrs. Abare. That's right. And as I say, we were very fortunate, you know. We have a little reputation. I'm new to the islands, but I don't think I will get thrown out if I stay. We have a reputation that you can't get people from 5 towns to sit down and work together and do things because each town is a separate town within the island community but we have been very happy and very pleased and proud that we have at all our meetings have a representa-tion from all 5 towns and they are all represented tonight.

Senator LEAHY. Thank you.

The next person we hear from will be Betsy Davis from the VNA.

STATEMENT OF ELIZABETH J. DAVIS, EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION, BURLINGTON, VT.

Ms. Davis. Thank you, Senator. I feel as though I have had an unusual opportunity all day long today and have been heard amply by the Senator and his group, so I plan to be very short. It's been a gratifying experience for us to work with the communities and the county, and there are just a couple of points that I would like to make and much of this is in relationship to some of the hearings and discussions that we heard today. It's been encouraging to hear the real concern for getting health services, a total range of health services out to rural areas in a more comprehensive way. The major point that I'd like to stress is that we feel we are a part of a system of health and I know "system," that word gets overused greatly, and what do we really mean by a system? What's important is that system cannot depend on any one individual, no solo practitioner whether it's a physician or nurse practitioner or a paramedic, that whoever practices in a rural area must be tied to a system of health care, and that actually applies to an urban area as well as a rural area. That system must guarantee quality. Those of you who live in a rural area are entitled to the same quality of service as those people who are living in an urban area. And I think, that it's that guarantee of quality that people in a rural area should depend on, not an individual, again whether it's a physician or nurse practitioner or paramedics. I think those people hopefully provide the atmosphere and ability for people to enter into the system so that whoever delivers the care the important thing is that they operate by the same rules and the same standards of practice and that they will be

audited for that practice.

I think today we heard a lot about supervision of nurse practitioners and paramedics. I think it's also important that physicians are audited and that the whole system is audited, and that is what people are entitled to. With a guarantee of a system, I think then we will remove some of the other concerns of medical students, of people going to the rural areas. Those concerns we heard this morning were: How does a physician in a rural area keep updated in terms of continuing education to make sure that they are relevant in terms of the practice they are providing; that they would have a supporting system so that they would not spend 24 hours a day and some of the nights up delivering services by themselves; that they have the backup support from a system of care so that they can get back for continuing education and other kinds of things that are necessary for the survival of anyone practicing anywhere whether its rural, again, or urban. I think the important things that we have tried to accomplish with the health center is to, first, to provide a method for people to get into the health care system I think it was impressive to us to see by our experience on the mobile unit that 33 percent of the children we saw had no source of preventive care. Another 45 percent of the children we saw on the mobile unit had irregular sources of health care and that many adults that we talked to would name three or four physicians as their source of health care. I think we as health professionals have done a very poor job in raising the expectations of you, the consumer as to what you should expect from the health care system, that you should be guaranteed a continuing quality service that is available 24 hours a day, again, no matter who is delivering it.

And, as an entry into that system, again, at the health center we are hopefully removing some of the barriers of getting into the health system whether they are psychological barriers or whether they are educational barriers or whether they are financial barriers or whatever they are. So that, again, I think one of their main functions of personnel is not only to deliver a certain level of medical services but to make sure that you are guaranteed easy entry into the rest of the system so your total needs are met. The nurse practitioners working there will help you get into the specialty diagnostic services, will help follow through so that you can get through the whole morass of the health care system now. I think the other most important thing is that we are committed to involvement of the community and the consumer as knowledgeable, responsible people, hopefully, in increasing your ability to define the health care system and what it should look like. Therefore, we are committed to the concept of the governing health council that has responsibility for program direction, services design, evaluation, feedback, so that we can continue

to change the system as the community defines it.

In addition, we are committed to the consumer and the patient in terms of you being fully knowledgeable about yourself and how you work and so that you can better take care of your health care. In the end its going to be you, the patient, who is going to make any sense out of this health care system that we are trying to improve.

I said it would be a few words so I will stop there. It's really been a privilege for me to work with this community, and I look forward to con-

tinuing development of the health center. Thank you.

Senator Leahy. Thank you very much. As I stated on behalf of the sub-committee—incidentally, there are, I have one member of my office, my administrative assistant here with me and four others from Washington, the two members from the Senate Agriculture Committee, Jim Giltmier to my immediate right and Warren Oxford to his right, as well as representatives of Senator Robert Dole's office and Senator Dick Clark's office.

Ms. Davis has testified twice for our subcommittee today as well as been involved in colloguy of a number of questions and answers at different times

throughout the day, and we appreciate it.

Earlier this evening the six of us had a chance, myself and five from Washington had a chance to go through the health center here with Sue Heath and just as an indication of how it is used even during the time we were having our tour there was a call for her services. But I would ask Ms. Heath if she would testify.

STATEMENT OF SUSAN HEATH, BURLINGTON, VT.

Ms. Heath. Ms. Sue Heath, nurse practitioner of the health center. I don't think I have a great deal to add to what Barbara and Betsy have already said. Barbara has stated nicely the center's beginning and Betsy has talked

about some of the concepts under which we are trying to operate.

From my own perspective as a nurse practitioner if I go back to when the health center started it was, I think, a beginning venture for everybody. We could say, here is something that we have to offer to the residents in the county and the health council was saying, we need some health care up here, so we got together and said let's try out a nurse practitioner as an extension of the system and see what she can do. I see many faces here of people who have used the health center, who I think have experienced what a nurse practitioner can provide and have understood what her limits are.

Betsy reviewed this morning that over the past year and a half we have been able to to take care of 93 percent of the adult problems and 95 percent of the children's problems so that only a small number have had to be re-

ferred on outside the county.

Although Audrey and I are the visible people at the health center, we represent a small part of all the services being provided. There are some of you who have experienced the other components of the system such as Dr. Rubin and Dr. Holmes providing the consultation that is needed for a nurse practitioner. Another important component is your involvement as consumers of the health center.

Everybody who's come to the health center has heard me say, this is what the problem is and this is what you can do about it; we want you to assume more responsibility so that you can have some control over what's happening in the disease process as well as understanding the degree of wellness

that you are experiencing and how you can maintain that.

Now, I don't think I have anything else to add.

Senator Leahy. Thank you very much.

I'd like to hear from the two doctors who provide backup and audit services, and I call Dr. Fred Holmes first.

STATEMENT OF DR. FREDERICK C. HOLMES, ST. ALBANS, VT.

Dr. Holmes. Thank you, Senator.

It has been an interesting day and I think, you know, if you think where we were during the day today and where we are tonight, this is where it's at. When you want to find out what's going on in rural Vermont, I think that my relationship with Sue and the people in Grand Isle have more to show for it

than all the years I have spent in Burlington.

One of the things that impressed me today is that much of what we discussed and many of the solutions that were offered seemed to be long-range things in terms of designing health care systems or of considering alternate forms of education, but I think, very briefly, that I'd like to touch on a few things that are immediate problems and the thing that is sort of fascinating is that these immediate problems are almost universally addressed by the Champlain Islands Health Center. The first one is I was rather distressed this morning to find out that I'm no longer viable as a solo practitioner. I had to keep pinching myself to find out that I can become extinct, but, in fact, in really rural Vermont I think most physicians are solo practitioners, at least all but three in Franklin County are, and we have about 15 or 16. Many of us have the luxury of cross-covering for somebody else when we want some time off, but, unfortunately, there are many of our peers who don't sign out for somebody and they leave their phone unanswered and in rural areas I'm sure many of you may have experienced this where you call for assistance and nobody answers, and if the doctor that you are used to isn't there when you call you may find yourself in a situation where you are not exactly sure what to do. I would suggest that an immediate solution would be what they have done here in the islands in terms of providing an answering service to alleviate these difficulties or at least getting some of our peers to cover for each other.

Senator Leahy. How is the answering service handled in the islands?

Dr. Holmes. Volunteer.

Senator Leany. And is that 7 days a week?

Dr. Holmes. All the time.

Senator Leahy. How many volunteers? Do you have any idea involved in this?

Dr. HOLMES. Three.

Senator Leahy. Three volunteers. They handle the whole thing?

Ms. HEATH. The calls go into the Villemere Health Center or to the phy-

sician the patient has already identified with.

Mrs. Abare. If I might mention, you know, when you asked us if we had plenty of money when we started. We have staffed the health center with 10 volunteers each week and these women come from the four southern towns of the county, and we have not had to hire anyone at any time to answer the phone or to do any of the other duties which even includes holidays so we do have quite a volunteer staff.

Senator Leahy. And what do the volunteer staff do? Do they handle every-

thing from the office clerical work going through-

Mrs. Abare. No; they don't have anything to do with patient's records. They answer the phone, make appointments. They babysit with children when the mother has to see one of the nurse practitioners. They are sort of a liaison between the professional team and public in the center.

Senator LEAHY. Thank you. Doctor.

Dr. Holmes. I think that another immediate problem which has been addressed very nicely in the islands is the whole question of public education in Franklin County which is not the best employed in the State. It's not at all unusual to have people who don't even know when they should go see the doctor, and once that they decide that they should they don't know how to go about doing it so that at peculiar hours they wind up in the emergency room for routine medical care where the cost is greatly exaggerated and they wind up in a situation in which they are no longer in control. Here in the islands as I have watched Sue and Audrey and the girls work, the education that they have passed out with the health care that they are providing seems to make a large contribution toward improving the health of the population. One of the things that's really my pet peeve and it bothers me a great deal is the cost of medical care.

In my practice in Franklin County 40 percent of my population is on medicaid; only 10 percent are on Blue Cross/Blue Shield; 30 to 40 percent have no coverage at all; and 75 to 80 percent are eligible for the food supplement pro-

grams, and that's a lot of people.

Senator Leahy. How much is the percentage?

Dr. Holmes. Seventy-five to 80 percent are eligible for the Wick program and that's an amazing percentage. Let's take for instance, and these are situations which are familiar with the people in the islands. If you are a farm laborer and have two or three children and you are only receiving \$100 or a little bit more than \$100 a week, but you get housing, half a dead cow and all the free milk you can drink, you are ineligible for medicaid. And if one of your children becomes ill, and I have checked on the statistics, and happens to walk into a hospital emergency room with a simple single ear infection that child will cost that family \$43. So it's not too hard to understand why we have difficulty promoting even routine crisis health care, much less preventive health care when the cost of the care is so handicapping to the people.

The other thing that's happening is medical care is becoming progressively more expensive for people who provide it through malpractice and everything. At the State's hearings on the malpractice issue there was a good deal of testimony about people cutting back practices and cutting back on services

because they can't afford to provide them any further.

The other thing that bothers me about the malpractice situation and then I'll be quiet, but I think it's a very important one. People keep considering malpractice in terms of its cost. Physicians have to charge more because they have to pay more insurance or they order unnecessary laboratory procedures, that do unnecessary X-rays. But the whole beauty of the system that we have in the Champlain Islands is based on an interrelationship between the health council and Sue and a backup physician. If something could be done to loosen up the fetters that you feel as a physician in terms of malpractice so that as a physician you could deal much more freely, much more openly with nurse practitioners who wanted to provide care for which you would be responsible as a physician, and this concept, this team concept for bringing health care to the rural areas could blossom in many other places. But I know many phy-

sicians in Franklin County who would be very reluctant to be in a situation that Al and I are in because they are a little bit hesitant in assuming the

responsibility for the care that the girls are providing.

Senator Leahy. Let me ask you a question along that line, Doctor. What are the use patterns? Who uses the facility? You must have some general idea of the population breakdown, men, women, and children for Grand Isle County. Is the use consistent across that population, equally used by men, women, and children, or is there a predominant use by children or women or men?

Dr. Holmes. I think for the proper answer you have to understand a little bit of the history. Sue and I have been taking care of kids in one form or another through the VNA for about 6 years now, 3 or 4 years before the health center was set up on the mobile van as it went through Chittenden County so that our experience has been almost exclusively with children. And then when she got to the islands and found a place where her services were in fact really needed, the obvious emphasis, because we had the format established and were comfortable with working with it, was to care for children, and then the adult component, if I am correct, was added on as the system evolved.

Senator Leahy. So there are more children seen proportionately?

Dr. Holmes. Yes.

Ms. Davis. Sixty to forty.

Senator Leahy. Sixty to forty? Sixty percent children and 40 percent adult?

How do the adults break down between men and women?

Ms. Heath. That hasn't been broken down statistically. I think probably more women use the center because at this point we haven't added extensive evening hours, and there you automatically eliminate a group of people.

Senator Leahy. You think evening hours would include more men because

they are working?

Ms. HEATH. I think so, yes.

Senator Leahy. Doctor, anything else you'd like to add?

Dr. Holmes. No, thank you.

Senator Leahy. Dr. Rubin, if we could hear from you for the record?

STATEMENT OF DR. ALAN S. RUBIN, UNIVERSITY OF VERMONT, BURLINGTON, VT.

Dr. Rubin. Dr. Alan Rubin, University of Vermont.

Well, it's been exciting to work with Sue and Barbara for the last 2 years, and I have reached a point where I feel almost superfluous and the interchange has reached a point where Sue calls me up 4 out of 5 days a week and says, "Alan, I have this person," and she tells me what she's going to do and I say, that's okay. It's rare that I say I'd like to see that lady or man, or I'd like to see that person go to the emergency room. And I feel that way because we are becoming part of a system and the system relies first of all on the patient. The patient is educated and demystified about what professionalism is and what a doctor means and is a patient who knows a lot about his health care and a lot about his body, and that is one reason I don't feel uncomfortable about prescribing over the phone to Sue's patients or giving advice over the phone because I feel we know our patients well.

The second part of the system is a record which comprises all of the patients' problems, and that is what we attempted to do with that health screening at the clinic. That is, it's a questionnaire, physical exam, and lab tests that give us a list of problems we really don't want to miss when and once we have that record we share it. After Sue sends that down to me or Dr. Tufo to review, we feel confident we know most of our patients' problems. If we don't

we ask Sue for more information.

Senator Leahy. Doctor, then you, actually you and Dr. Holmes provide, as well as providing care when required you provide this audit and backup?

Dr. Rubin. That's right.

Senator Leahy. System? For the record, how effective do you thing the audit and backup system has been?

Dr. Rubin. Very.

Senator Leahy. And do you think this is a model that could be used in other parts of the country?

Dr. RUBIN. I think it is.

Senator Leahy. Is it ultimately dependent upon the personnel?

Dr. RUBIN. No, it's not.

Senator Leahy. Do you have enough safeguards within the system itself so that if at some point it was used somewhere and there was inadequate personnel that would show up?

Dr. Rubin. I think it would. I think the ultimate safeguard is the patient who says, "hey, this isn't right, that's not what I said," and that's one reason

we'd like the patient to carry the record.

Senator Leahy. Let's go into that just a moment for the hearing record because we have had some discussion of this earlier today—this idea of sharing the record with the patient. This is not a traditional way of practicing medicine, is it?

Dr. Rubin. No, it's not.

Senator Leahy. Do you feel that it's a good method?

Dr. Rubin. I think it's a great method. I don't often know what I'm doing

wrong unless the patient tells me.

Senator Leahy. I wish we got this kind of candor at hearings in Washington. I think there would be a lot less problems with the Federal Government today. I might say as an aide it's good to come home to Vermont and get back to reality.

Would you say-and at the risk of leading the witness for the purpose of the record—would you say that sharing the record with the patient is really

a tremendously important part of the audit system?

Dr. Rubin. Yes. The ultimate is the patient audit both in terms of health care delivery and educating the patient about his problems.

Senator Leahy. Dr. Holmes, did you want to add something? Dr. Holmes. I think one of the things that has handicapped medical care for a long time is the mysticism that surrounds the physician and when you deal with people who are ill and you just say, this is what it is, and this is what you're going to take and who's next? There's something missing, and it's a great deal more beneficial and productive for all involved if you can sit down with them and talk to them about it and let them ask questions and exchange interpretations or opinions, you know, to make the whole relationship more satisfying for all involved.

Senator Leahy. Thank you, Doctor, did you want to add anything?

Dr. Rubin. That's it.

Senator Leahy. Thank you very much. I appreciate the time of the witnesses. I'd emphasize again that the hearing is being done for the Subcommittee on Rural Development as well as Senator Kennedy's health subcommittee. We are looking at models for Federal programs rather than programs for the State of Vermont or the State of Iowa, or the State of Massachusetts or any one particular State; and it has helped enormously all of the people who have testified today, but we have a lot of people here who use the program, and one of the reasons for taking these hearings out of Washington away from the Senate back to local areas is to hear from the people who normally don't testify. So I would like to throw it open to anybody who would like to give their own feelings about the health care system used here and the program used here. Anybody who'd like to ask a question of any of the ones who have already testified here tonight? Maybe what I might suggest we do is take about a 3 or 4 minute break so that the stenographer can rest her hands and think of things you might like to say and then I really would like to hear fom you. It would be extremely valuable not only to me as one Senator, but to the rest of the members of the Senate so if we take a 3 or 4 minute break then we will come back at 8:30.

[A brief recess was taken.]

Senator Leahy. I want to thank the health council volunteers who contributed to the coffee, cookies and cake tonight. I want to tell you, however, that you have done terrible things to my health and having finally taken a vacation for the first time in a long time I have gained weight and this hasn't helped a bit, but thank you very much for doing it.

In all seriousness, it's extremely important for us to get whatever feedback we can so is there anybody here who would like to talk about the health

service?

Mrs. Porter. My name is Ann Porter and I'd like to make a comment on my health care. My two girls have both been to see Sue Heath many times with various childhood complaints. The problem that I have encountered is that Blue Cross/Blue Shield, purchased through the Burlington school system, provides for office visits, and as far as I understand it, we are not reimbursed for visits with nurse health practitioners. I would like this to be on the record that this is a problem for us. It's so much more convenient to go to the health center here in the islands than to go into Burlington; at the same time when I do go into Burlington, I'm losing money. It would be a great help on the whole matter of insurance coverage if visits to professionals other than physicians could be covered.

Senator Leahy. Let me mention that we went into this at some length this afternoon at our hearing in Burlington, but at the risk, again, of somewhat of a leading question, can you see any sense whatsoever in the rules that prohibit payment for you bringing your children to a nurse practitioner?

Mrs. Porter. Well, no, it wouldn't make sense.

Senator Leahy. You have felt very good about the care, I take it, you re-

ceived for your children?

Mrs. Porter. Absolutely, yes. My one daughter who has had serious problems, had been referred to a specialist in Burlington, but for routine hearing tests, ear infection treatment, Sue has certainly done a marvelous job.

Senator Leahy. I would state for the record again, as I have several times today that I see no sense in the fact that third-party payment usually cannot be made to a nurse practitioner, and agree with you and I thank you very much.

Yes, sir.

Mr. Duffy, My name is John Duffy from South Hero. I'd like to point out the inconsistency in the policies of the insurance companies in that respect. Like Mrs. Porter, we are insured in a group and my employer is Vermont State College. We are not insured by Blue Cross yet all of our visits to the health center and services provided by VNA through them are covered expenses under our policy with another insurance company. We find that very fortunate and convenient.

Senator Leahy. And I take it also, Mr. Duffy, that you feel that for, certainly for a number of areas that utilization of a nurse practitioner is ade-

quate for the type of medical care that you need?

Mr. Duffy. Right, and economical considering the cost of a trip from our south end of the island into Burlington at 10 cents a mile is still \$10 a trip. Senator Leahy. How far is a round trip, just for the record, from that end

of the islands into Burlington?

Mr. DUFFY. It's a 40-mile round trip.

Senator LEAHY. Doctor.

Dr. Holmes. Just a fine point. I think that we are discussing reimbursement for nurse practitioners. I have heard discussion that reimbursement should be different depending upon who is providing the services. I think its important that the reimbursement be on the basis of the services provided regardless of who provides it.

Senator Leany. Are there other—yes, ma'am.

Ms. Zehle. Elenore Zehle, I went through the screening program a year ago and Sue Heath referred me to Dr. Rubin, since I did not have a family doctor. Dr. Rubin, after further testing, suggested a surgeon who handled my operation in the hospital through the health center; this service was provided for me

Senator LEAHY. And did you feel that the care at each level which you received was good and adequate care, and that you got referred on at those steps where it was necessary to refer you on to somebody who perhaps was more expertise in the field?

Ms. Zehle. Yes, and they told me exactly what was going on, too, what Dr.

Holmes said before.

Senator Leahy. Did you feel confident about what you were hearing and what you were being told about your own record?

Ms. ZEHLE. Yes, I did.

Senator LEAHY. Thank you.

Mr. White. I'm Bob White; I work for the Vermont Extension Service, county agriculture agent here in Grand Isle County. As you know I worked in education and we do try to do a bit in health education. That's why I wanted to make a point of stressing that we can't cover every educational need of people in health, and I'm sure that many of the other people that work in the health center and in the area are doing educational work, too. Just a

few of the things we do do. Beverly Rock is our nutrition aid and I think foods are vital to health, and so we feel that we are doing a job with a few people. We are not reaching any percentage at all in the county, maybe 20 or 30 families. In our 4-H program we have physical fitness programs and food programs and we have done work in the area of drugs and drinking and smoking and harmful effect of those things. I guess the point I'd like to make is that in the whole health program in Grand Isle County I think some consideration might be given to the need for a stronger educational program to cover more of the people to, as a health preventive measure, and not helping people that are already sick.

Senator Leahy. Anybody like to actually like to add something or refer to

Ms. Heath. I would just like to add that a very important emphasis at the health center is the preventive component. I think this is one of the main reasons for our existence. Preventive services have been provided at no outof-pocket expenses to the patient. This and health education are the cornerstones to helping people understand more about themselves and assuming more responsibility for self-care. The second part of that is providing the patients with their records. We haven't gotten into this with children but do see it as a goal. For each person who has a screening examination, a copy of complete information and recommendations is sent. For example, in the letter it might say, we found on your screening exam that you are 25 percent overweight and state that if you want to prevent high blood pressure risk, possible risk of heart disease or diabetes, then you need to lose 20 pounds. That's an individual health education focus. We don't know yet how effective its been. Its very hard to measure except some patients have come back and said, its one thing to tell yourself that you are overweight and its another thing to see it in black and white. I think Mr. White addresses another community issue and that is public education. Right now there are parent classes, preparation for parenthood, and childcare classes going on, but that's just a small start

and there are a lot of other health education needs, group needs.

Senator Leahy. Incidently, one of the things that I did not mention at the outset of the hearing tonight, when we leave here I will keep the record open for 2 weeks and during that time if anybody thinks of anything further they would like added to the record they can send it to me in the form of a letter at the Senate in Washington, and I will make sure that it is included as part

of the permanent record.

Are there other statements anybody would like—yes, sir.

Mr. Denkinger. I am Esty Denkinger. I am a farmer in Grand Isle and a refugee of some 4 years from urban areas where I have seen in two specific cases that I have been directly involved with millions of dollars spent without the achievable, tanglible results that these people have accomplished on thousands, literally, and its with some of that background in mind that I'd like to ask Barbara—I think this ties in with the concern of the distance that we find ourselves here from excellent major health facilities in Burlington, at least, but about emergency facilities, do you really feel that you are adequately equipped here to handle emergency type of things, major well, maybe not major, but certainly the type of things that would require fairly instant service rather than transport to the additional 30 miles to Burlington? In other words, do we have fairly adequate X-ray facilities, fairly adequate emergency room facilities, and this type of thing? Do you feel a need for this?

Mrs. Abare. Are you talking about in relation to the health center, Esty? Mr. Denkinger. Yes. I'm asking do you have them and if you do not have them is this something that you really feel that you should have?

Mrs. Abare. Well, you know, actually, we'd love to build a little Mayo health center up here, and I think the people in this county deserve much more than we have, but no, we do not have X-ray services for two reasons: One, we don't have the room in the present center; we do not have the X-ray equipment or the funding to buy it, and we do not have the staff, you know, the X-ray technicians. And, again, it would be a matter of someone to read the X-rays immediately and we don't have that person. I think for the record that everyone in this room knows how heavily we rely on our emergency transport services and our EMP and our first aiders, and this is an active program in each town in the county. And we have to be transported from Grand Isle 50 miles to Burlington; from the northern part of North Hero into Burlington is 60 or more miles round trip, and I don't see where these things will be available in the immediate future at the health center unless we suddenly, as I say, have a windfall. God knows what. We would very much like it. We would very

much like to develop to a point of being able to have.

Mr. Denkinger. Second comment, and really by way of commendation again, I guess that despite a good deal of previous association as a clergyman with people and with health care delivery services that I had never really realized how put off people are by the mystique that surrounds health care delivery things until I got out here and got to know a number of the type of people who are put off by this firsthand, and I would stress the need for a continuation of this, of the very personal one-to-one type of thing that you have been doing because I think you are rapidly reaching a section of the population that you would, that would normally not go near a health care facility short of imminent death. Doing very well on this, and I would ask to what extent are you being successful, I'm thinking, with older people on this who may not have ever had much experience with health care delivery things?

Mrs. Abare. Well, I think maybe someone else could speak better to this.

Let me just speak to it, then I'd like to refer it to Sue.

I think we have found here in the islands that we have to look at health care for older people in two ways, and I'm not going to speak about quality of health care they receive, but because there has not been a physician permanently in the islands for about 20 years people have set, older people have set up a pattern whereby they go into Burlington. It is a grocery shopping day. They go to the pharmacy. You see your physician. You get your feet care. You call on your relatives and come home, and it's a very important for the reason that many people who are in this pattern have been reluctant to change it because they were really wondering how long we were here for, and you are not going to give up your association with a physician unless you are sure that an onsite health system is going to continue. And I think also too that we have to stop—I'd like Sue to speak to this—that you have to stop and think of the health problems of the 35-, 45-, 70- and 80-year-old person are different than some of you younger people. Sue, do you want to add anything to that?

Ms. HEATH. Yes. I think one of the difficulties that we have struggled with is that many of the health problems of the elderly are much more complex. If a person who hasn't been seen before at the health center comes in and they say they have a cough, I don't know if their cough is because of complicated underlying chronic lung disease or if they have pneumonia; or if they are going into congestive failure. So what we are trying to do through the health screening examinations is to establish a base for understanding what this person is like when they are well, and what are their problems when they are presenting as a well person. Then when this person comes in with an illness we then have more understanding of their illness. So until we get somebody's baseline data, providing quality care to the person who has a complicated health picture is difficult, and this has been our limitation. And, also, just in terms of my starting out with a pediatric focus and then changing to adult care where things are more complex I am going to limit what I am going to provide to a person until I have a full understanding of what is happening. That's my own audit on myself.

Senator Leahy. I might ask along the lines of how much can be done? Ms. Davis, how is the system financed as it is now and how much is the cost per

visit or have you broken it down to that?

Ms. Davis. Presently it's financed through several grants, patient fees and volunteer hours, the grants we have this year are a carryover of an HEW grant and health department funds. We have applied for some RMP funding and have applied for rural health initiative funding. We do believe that rural health care cannot be fully supported on a fee-for-service basis if we are talking about total preventive service. Our cost per visit in the first year of operation was \$11.55 overall, and we don't know where that will go. That includes the screening services and laboratory services that we are also providing. I'd just like to add to the comment in relationship to the elderly population. I think the important part of the health center is the integration of home health services and the nurse practitioner Audrey who works with Sue at the health center, her major responsibility is home care. So our main way of reaching that population at this point is on a home-visiting basis, and Grand Isle County had a very high utilization of that particular service, I think that's

partially a reflection of those elderly people who are significantly home bound and have a difficult time getting into medical care and the best way to reach them is on a home-visiting basis.

Senator Leahy. Anybody else? Sue?

Ms. Heath. I'd like to ask a question of the audience. This morning we heard a lot of testimony about health centers in other rural areas of the State where the base provider was a physician, and I haven't been in the county for a long time, but by what I am told, there have been a number of physicians who have come and gone out of the community for whatever reasons. I would just like to hear from some people what its like for them to use a nurse practitioner instead of a physician, what this means to them, what they see is the limitations because I think it is unique.

Senator LEAHY. Ma'am?

Mrs. Frechette. I am Marcia Frechette from South Hero. I have two small children. Prior to the health center opening I used a physician practicing in Burlington for my children. I have a child who has many neurological problems and in the physician's practice it was, as you say—"What's wrong?—quick, in, out, and you have got 5 minutes to explain it." And with Sue we worked a long time, a lot of visits to establish that I had a child with borderline problems. There were things that could be done for him, but it was a lot of visits and a lot of long talking visits, an hour which you never spend in a physician's office over one child. You don't sit for an hour twice a week to establish what's wrong with your child. This has been a really important part of the care and also the educational process. This is what you can expect from the course of illness and if this happens do this, and if that happens do that, and it's all written out and there is a paper to take home. If you have any questions you can refer back to the paper or you can call the center.

Senator Leahy. Did you find it an important thing to have access to that record?

Mrs. Frechette. Yes; I have a piece of paper that tells me what to do. I don't have to rely on my memory, a lot of things have gone on in an office visit and its all written down so that I have got it all there when I get home,

not just what I remember of it.

Mr. Bonfanti. Esty, I am not trying to one up on you. My name is Attilio Emilio Bonifanti. I am only going to speak as a person who has lived in the community that you probably won't hear from. That is that we, my family and I, have used the health center on one occasion. We haven't used it as much as we should have or could have. We used it on one occasion. It was an emergency. They did an excellent job by us. They did a better job by us than we did by them. But, and I'm not trying to find any excuses for this. Its just that I, as the average person does, think they are too busy to take care of their health the way they should, but the very fact that they are here makes us breath easy, makes us feel better. We know they are available. And this is a feeling that a great many people continually express. Now, these are people that don't necessarily use the health center at all, but they are so grateful they feel so relieved that this anxiety isn't part of their life anymore. I just thought I'd throw that in for what it's worth.

Mrs. Duffy, Barbara Duffy, from South Hero. I would just like to agree with our friend with the very long name from the back of the room. I think it makes all of us breath easier to know the center is here. I have two young children that have had chronic ear and upper respiratory problems. Some of their problems cannot be handled at the center, but Sue and Dr. Holmes and the physician that cares for their allergies do it as a unit. As my children grow older they are becoming educated, not by me which is my job, but frequently children learn a lot better or understand more or are more willing to accept a rationale from someone that they like and identify with and someone that makes them feel better. And if Sue said, to them, no, you can't go to the ballet performance because you have an upset stomach and they say, but I want to go, she says, well, I'm sorry, you can't go. They just say, I don't feel very well anyway. If I had said you can't go they would have said. I have to go. Its an educational process for the children, and I think this is where possibly the educational process for everyone should be when they are young. These are things we overlook. Its easy to overlook these kinds of things. If you say, take your medicine and they say why, you say because I said so. They will do it but in many cases if they know why they should do it and

then they begin to understand their own response to not feeling well. They are able to tell you before they are really in an acute stage of disease process, you know, they really don't feel well. Maybe they should go see Sue or Dr. Holmes and they have come to learn that this is a good place to go, to respond to the kind of care that they receive, and to be very happy when you say, OK, we are going up, to go up to see Sue and she's going to tell you what's wrong. You call up and Sue's not there today and Audrey is there and she's going to tell you what's wrong and you are going to feel better. They feel much more comfortable. I feel much more comfortable. I also take better care of myself because when I go up there and Sue says, well, you don't sound very good either. I say, well, you know, I have been up for 5 nights and she'll say, well, why don't we culture your throat while you are here, et cetera. This is kind of a parent trap which I may explain to some extent why you are probably getting more female adults than you are getting male adults because most of the female adults are taking care of the young children in this area and you take them up there and you yourself get some acute care and then you think about it and you think, well, I take my children up there. I tell them they really should take care of their body and maybe I should set an example.

Senator Leahy. Do you use it for preventive care as well as-

Mrs. Duffy, Yes.

Senator Leahy [continuing]. The fact that you now have a sore throat? Mrs. Duffy. Right. We use it for preventive care as well as acute.

Senator Leahy. Doctor, did you have an—— Dr. Holmes. If I might address briefly the mom's comment about having an opportunity to talk for an hour, and what happens and why working in the islands is fun is because that's one of the very pleasant luxuries about it. The point I'm trying to make is that in this day and age on a day like today you can sit down and you can contemplate and you can discuss various alternatives for funding, manpower location and outcome in the abstract which is truly a luxury if you enjoy taking care of people, and what happens is in my practice or I suspect in most practices there is a certain amount of time that you have available to address a patient partially because of the number of people in the waiting room which means that perhaps my practice is not properly fitted to the geography, you know, the population that it serves, and partially because I think my indebtedness per year to keep my solo practice office open is greater than the Champlain Islands Health Center at last count. So that what happens is because of the system I wind up practicing medicine as opposed to the system that Susie winds up practicing medicine is there is a financial element that we can't deny. And the point I'm trying to get at all the way around is that wouldn't it be a lot better if not only could we remove the financial burden or barrier from the practitioner, but in particular couldn't we move it from the people who have to look for care? As a physician it hurts a lot sometimes to see people 3 days too late when you know they didn't come in 3 days sooner because they didn't think they could afford it or to see them, give them a prescription and know that it probably won't be filled and knowing you can do nothing about it because of that financial barrier that is always present. If there was some way, some how you could do something, just eliminate that variable all together, call it whatever you will, whether its my office or Burlington or the islands everything would be better and then we could all sit and chat.

Mrs. Frechette. It's more a question of, I think, attitude than time. It was an attitude where Sue was interested as a human being and interested in listening and saying, here's a mother. She spends 20 hours a day with this child. She sees something the physician implies, you don't know anything. We are being educated, I was educated to look at my child and evaluate what he was doing and saying, is it this or is it that? And Sue has educated me so I can give intelligent reports back. The physicians just didn't bother with this.

Senator Leahy. Before we wind up, I was wondering if I could call on Audrey Noel for one comment. Miss Noel?

Miss Noel. Can I answer from here?

Senator LEAHY. Certainly.

Miss Noel, I understand, and I don't mean to be putting you on the spot by calling on you, but it's a fairly informal hearing. In fact, I think it's only about the second time the Senate Agriculture Committee has had an evening hearing. The first time was one I conducted earlier on Bristol Cliffs in Bristol, Vt., on the Bristol Cliffs matter.

Miss Noel, as I understand it, you were a nurse and did not work for a number of years, but you are now taking the nurse practitioner training pro-

gram, is that correct?

Miss Noel. Yes, that is true. I had been out of nursing for 10 years, and then I had the opportunity to work for VNA and at the same time take an adult education course which has been completed and have been employed by VNA for 2 years. And I think at the time I came back I was debating, am I going to come back? Am I going to stay home? And this opportunity came up and it's really a, you know, a good way to get back into nursing—and I found nursing much more exciting than it had been 10 years ago when I left.

Senator Leahy. Did you find it all that difficult to get back in?

Miss Noel. Not really, not as difficult as I had been dreading for years that I just could not get—but I think it was a lot more to nursing than when I had left, but I really did not have, you know, did not have a hard time.

Senator Leahy. Did you find that the talents that you had acquired earlier as a nurse, did they stand you in good stead? Did they give you a good foun-

dation on which to work with the training as a nurse practitioner?

Miss Noel. Yes, I believe they did. I think otherwise having, you know, come back into nursing and having a family and taking on the education component that it would have been too much at one time, but I think I did have a good——

Senator Leahy. Is it safe to say that there are a lot of nurses like you who have been out of nursing for a period of time and have the capability of doing the same thing that you did, that is, take the nurse practitioner training program and come back in?

Miss Noel. I feel certain that they could.

Senator Leahy. And do you feel that you can then have something to provide, something to give in a program like the one here in the islands?

Miss Noel. Do I feel that I have something to give?

Senator LEAHY. Yes.

Miss Noel. I hope I have, you know, added something to the, you know,

health care system in the islands.

Senator Leahy. I know you have and as I said. I'm sorry to single you out in this, but I did want to make the point for the record that there is obviously a reservoir of talent. I do not know the statistics of people who have been nurses and then left the nursing profession to raise families or for whatever reason, but there is that reservoir of talent. I know a number of situations in the State of Vermont and I'm sure its the same everywhere else. Thank you.

Before we wrap up, was there anybody else who had something to say that

I have missed or haven't called on?

Dr. Rubin. I just want to say I think it would be impossible for a solo practitioner to provide the kind of care that the health council and the health center provided in this area, both in terms of education, availability, and financial viability for the practitioner himself.

Senator Leahy. Thank you, Dr. Rubin.

Ms. Whittlesey. My name is Margaret Whittlesey. I am from North Hero. I'd like to just get back to what Mrs. Abare was saying originally about the way we got into this and our feeling of wanting to have some local input, planning for ourselves and being responsible for what takes place here.

I think this so-called nine angry women group was simply a response to the notion that someone could sit in a place 30 or 40 miles away and decide what was going to be good for us. We felt that maybe they did know many of the things which would be good for us, but that we knew a few things, too, and

we needed to have a partnership.

I think it was a very fortunate situation for Grand Isle County that the Burlington Visiting Nurse Association was able to offer services to each of the towns. We voted to make just a token financial contribution. In each of our towns, we were given the opportunity to have representation on the VNA board and this began to build bridges and made it possible for us to have Audrey employed full-time in the county. Then through the interest of Mrs. Davis, who has really done yeoman duty for us, we were able to identify some other ways in which we could expand the services here. I think the important thing to have come out in the record here is that there has been this local input. I don't know what the latest count is, but a month or two ago we had

put in at the health center, not including the 24-hour evening, and the weekend coverage of our phone, we had put in better than 4,000 hours of volunteer time.

If the situation here is being looked at as a model, some of these components really need to be looked at because this means that we have done what we could, given of our talents where we didn't have the money to put into it. There has been this partnership and this has been the terribly important thing. I would hope that we would not get into a situation in the future where somebody is going to sit in some far away place and say, this is how the medical care is going to be planned, because I think it would tend to destroy what has been built here. I think you have heard this evening what it's about.

Senator LEAHY. Thank you.

Mrs. Frechette. I was just going to speak to your idea of nurses who are out and possibly coming back to practice. Part of this will have to be when institutions take into consideration that there is a big pool of people, but we aren't in the Army, and they may have to change their staffing patterns and ways of getting nurses back into practice. There's a tremendous pool of nurses available in the country, but they can't work a 40 hour week and the crazy hours that the hospitals want to do or any of the institutions. Some of the institutions are going to have to change their staffing patterns to meet human needs.

Senator Leahy. I know at least one nurse who would agree with you very very much. In fact, we should have called her as a witness here today.

Mrs. Abare. May I mention one thing? I don't know if this country is unique with this problem, but it is one area that I have lived and worked in and have found that for every human service that we want we have to leave this county almost without exception. If you have—I work as town service officer and if I want to take someone for medicaid to St. Albans as I did last week I have to drive 90 miles round trip with them only to find out that the medicaid application was filed last August are just coming through now. If they need social security or any other human service we either go to St. Albans or Alburg, and it really is a serious problem when you live in a county 50 miles long as this county is. As you know, we touch New York and Canada and southern Vermont, and you find that there isn't a service available onsite within the county. And this is probably why this health program or health center has and does mean so much to us because it's just a beginning.

Senator Leahy. One of the main reasons I urged the Subcommittee on Rural Development to come here is that these problems can be translated to the problems of some of the counties in Iowa or North Dakota or even parts of California or Oklahoma or so many other places. These problems are not unique, but I am concerned that very often they seem to feel in Washington that they are and forget the fact that there are an awful lot of people in this

country that live in a rural area.

I think in wrapping up, Betsy Davis, if I could just ask you a sort of wrap up question. What can Congress do to help? What should Congress do to help? Think of the lobbyists who would give anything to have a chance to answer a question like that.

Ms. Davis. I am flabbergasted. What an opportunity.

I think that what is significant is that you are here and have heard and I know that you will take a great deal back with you to Washington. I think the problem is multifacted, certainly in terms of the traditional health care system, the political support that continues to support an archaic approach to delivering comprehensive care. I think there are some specific areas that we have talked about today in terms of Federal regulations that promote only physician delivered services, lack of reimbursement for nurse practitioners, no real approach to a system of care. And I hope that's what Congress will look at. No one can do it alone, whether its a physician or a nurse practioner or whoever. What ever financing we have, hopefully it will encourage a system of care and one that has responsibility to the people, an accountability and a system of audit. Whatever legislation we need to encourage that I'd be happy to draft it.

Senator Leahy. It's also a fact that within those guidelines that areas are going to be able to tailor their programs to fit that particular area. In other words, the program that might fit in Grand Isle County might not fit in a northern county in the State of Oklahoma or whatever. Provided you had that audit ability and you have the——

Mr. Davis. Right. I think any system has to have some flexibility. I don't think there is any one approach, but the main thing is that it is a system of care, and I think audit of that system is probably one of the most important ingredients that is badly missing right now.

Senator Leahy. Thank you. For the record, I will recess these hearings,

and-

Mr. Bonfanti. I would like to make one last statement on the insurance. I think this is extremely important as far as we are concerned here in the islands. It doesn't relate to you, Senator, but it does to us. We have got a wonderful man in Montpelier as the commissioner of banking and insurance. This guy is really out to work in our benefit. If we swamp him with letters saying let's get the insurance companies to cover us in our important needs, rather than, for example, Blue Cross/Blue Shield which was started by the doctors, promoted by the doctors, and owned by the doctors, to pay the doctors. I am incensed that I have, that I pay in about \$560 a year and I can't get a nickel's worth of coverage as far as the health center here is concerned. I feel I'm being gypped, and I feel that everyone who has health insurance is entitled to be covered by the types of things that can be taken care of by the people here in the islands. If we swamp the commissioner of banking and insurance with letters to this effect I think it will have some tangible results.

Senator Leahy. You raise a valid point on the insurance question and we went into it at some length at one of our hearings this afternoon. I hope the news media was there. I hope that they will report it accurately and fully because I think it goes to the crux of this whole thing, not only the private insurance question but also the question of how medicare and medicaid pay-

ments and other types of third-party payments are made.

I will recess the hearings now. We will keep the record open for at least 2 weeks. Any of you who feel you have additional comments you would like to make, areas where you disagree or agree or have suggestions, send them to me at the U.S. Senate in Washington and I will make it part of the record. Any of you who have testified tonight, if you haven't filled out one of these things, please come and do so because we will send you copies of your testimony.

I can't thank you enough for coming out on a winter's night for this. It certainly shows your own commitment to your program here, but its extremely important for us in Washington because even though there may be some who have in the past felt that they have all the answers I think most of us realize in the Congress that we do not have all of the answers and that we don't even have all the questions. But we are trying to get them and the only way we can is in truly representing all of you and you help us do that and I applaud you all for taking the time, and thank you very much.

[Whereupon at 9:30 p.m. the Subcommittee on Rural Development ad-

journed, subject to call of the Chair.]

STATEMENT OF HON. DALE BUMPERS, A U.S. SENATOR FROM ARKANSAS

Mr. Chairman, I appreciate your giving me the opportunity to appear before the Rural Development Subcommittee to speak in favor of S. 708, a bill which would provide Medicare reimbursement to cover the reasonable cost incurred

by primary health-care clinics.

Arkansas has an extreme health manpower shortage at the present time. According to an American Medical Association survey, as of December 31, 1974, Arkansas ranked 48th among the 50 states in physician population ratio. That is, Arkansas has 83 physicians for 100,000 people providing patient care. The national average for physician population is 132 physicians for 100,000 people. It would take an additional 1,000 physicians for Arkansas to equal the national average.

The Public Health Service has declared 29 counties in Arkansas as critical

health manpower shortage areas.

Arkansas is also faced with an extreme distribution problem. At the present time there are 1,635 patient care physicians working in the state. Approximately one-half of these physicians are located in Sebastian and Pulaski Counties, two counties in which 20% of the state's population is located.

This health manpower shortage is critical in Arkansas. When I was Governor of Arkansas, I appointed a primary health-care committee and charged the committee to design a program to meet the primary health-care needs of the state.

All of the recommendations of that committee have been enacted. The State of Arkansas has created six area health education centers and three fully accredited residency programs in family practice in different areas of the state. A scholarship program for medical students who would agree to practice in rural areas of the state has also been created.

One of the major components of that program was the development of a physician assistant training program to meet the rural health-care needs of

the State of Arkansas.

Funds were appropriated to start the physician assistant training program. However, the State Medical Practice Act did not provide authority for physician assistants to function adequately in the State of Arkansas.

This problem was solved this month by the passage of Act 459 by the 1977 Arkansas General Assembly which provided for the certification of physician-trained assistant by the State Medical Board. The passage of this Act will allow the state to recruit physician assistants from throughout the country.

At the present time there are several clinical nurse practitioner training programs in operation at the University of Arkansas' School for Medical Sciences. A five-year baccalaureate program graduates 40 to 50 students per year. A clinical nurse practitioner post-graduate program has approximately 20 graduates per year, and a masters clinical nurse practitioner program graduates approximately 20 graduate students with masters degrees each year. However, these graduates have difficulty fitting into the existing health-care

delivery system.

It is my understanding that Title 18 of the Social Security Act does not expressly recognize health-care clinics or physician extenders as providers. Physicians practicing in primary care clinics are reimbursed by Medicare for their own services and for charges for services "incident to physicians' services" such as laboratory and x-ray services. However, Medicare does not reimburse for nursing services outside of a physician's office unless they are performed under the direct supervision of a physician. For example, if a nurse accompanies the physician on house calls and administers an injection, the nurse's services are covered; if the same nurse makes the call alone and administers the injection, the servees are not covered since the physician is not personally supervising the injection.

This distinction in our Medicare laws is absurd. The result is inequitable for patients in rural areas. The effect of this policy has been to completely exclude from reimbursement the satellite clinics, which are increasingly prevalent in rural areas. In these health clinics, a physician extender provides services to an isolated population under the general, but not immediate, supervision of a physician. As a result of the coverage exclusion, Medicare bene-

ficiaries in such areas are denied the benefit of the clinics.

This treatment by Medicare is inconsistent with the actions of a variety of federal health programs, which have been instrumental in promoting the physician extender concept, both in the form of training and in grants to

underwrite initial operation of clinics.

In light of the extreme medical manpower shortage which we have in the State of Arkansas, I am extremely interested in the development of the rural health-care centers. There are data available demonstrating that the use of medical practitioners can expand the basic load of medical practices. A study of physician extenders, including nurse practitioners, commissioned by the Health Resources Administration of the U.S. Department of Health, Education, and Welfare, concluded that "given the assumed task delegations and the expected level of acceptance, the median estimate of the need of physicians in the target years (1980, 1985, and 1990) could be lowered by as much as 22%."

In a study reported in the New England Journal of Medicine in January, 1974, the addition of two nurse practitioners enabled two family practitioners to increase the number of families under their care by 22% in the course of

a year.

The evidence that is available on the quality of care rendered by nurse practitioners has been favorable. A key ingredient of the quality control in

all reported demonstrations has been the active involvement of physicians, who audit the work of the nurses, establish protocols for their practices, and visit the sites periodically to see the patients and consult with the nurses.

Controlled studies have generally shown the patients to be as satisfied with the care provided by nurse practitioners as they have been with care for similar problems provided by physicians.

Recognizing the extreme importance of clinical nurse practitioners and nurse clinicians in the delivery of primary health care, I recommend one amendment to S. 708. "Clinical nurse practioners" and "nurse clinicians" should be distinguished from "physician extenders" in the bill. Clinical nurse practitioners and nurse clinicians provide services beyond and in addition to the services offered by a physician. For example, they often provide continuing care or overall supervision to patients with long-term illnesses. They represent a separate type of service which is generally needed in rural health clinics and should be distinguished from the services of a physician assistant.

A number of innovative approaches to primary health-care delivery are being tried throughout the country, and especially in the rural South. However, much more remains to be done. Many of the projects currently under way may prove to be short-lived without some fundamental changes in governmental financing programs. Most approaches are being tried on a small scale. That falls far

short of meeting the total need.

I congratulate you, Mr. Chairman, for introducing this legislation. Passage of this bill would provide access to Medicare benefits for thousands of eligible beneficiaries who now reside in areas designated as medically underserved. It also would provide a financial benefit to the Medicare Trust Fund. If the patterns of early primary health-care clinics continue, Part A savings on hospitalizations should be substantial. Recent studies showed reductions of 52.7 per cent in Memphis clinics, 70 per cent in Hyden, Kentucky's Frontier Nursing Service, and 35 per cent in the neighborhood health centers.

STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS

Mr. Chairman, members of the committee, I appreciate this opportunity to testify in support of S. 708, the Rural Health Clinic bill which I have co-

I would like to mention that Texas is well-represented in this hearing today by the presence of Mr. David Walston and Mr. Jim Clayton of Plainview, Texas. Plainview is a community of 20,000 people with one physician surrounded by several smaller communities with no physicians. Mr. Clayton is the Director of the South Plains Health Provider Organizations, and Mr. Walston, who will be testifying this morning, is a physicians' assistant in that organization. The organization provides health services for the underserved area of Plainview with the help of a grant from the Department of Health, Education and Welfare and the dedication of people like Mr. Walston and Mr. Clayton.

S. 708 promises a great improvement in the availability of health services to those living in rural areas by allowing Medicare to reimburse health clinics in rural areas for services provided by both physician assistants and nurse

practitioners.

For too long, the federal health insurance programs have refused to recognize the harsh realities that face health care delivery systems in the rural areas of this country. The current programs limit their payments to physicians only. However, very few rural areas are lucky enough to have physicians. Let me give you some statistics at this point. I think they will serve to illustrate better than anything I could say just what the aged and disabled Medicare beneficiaries who live in rural Texas can expect due to reimbursement policies under current law.

23 counties in Texas were wholly without a physician as of the last count on December 31, 1973. No other State in the country has as many counties

without physicians.

Of the 957 counties in non-metropolitan areas of this country with the highest incidence of infant mortality, 172 are in Texas. Again, Texas has more counties with this kind of high infant mortality rate than any other State.

Of the 971 counties in the Nation that have been designated by the Department of Health, Education and Welfare as "critical health manpower shortage areas", 49 are in Texas. Only Kentucky has more counties so designated.

Of the 2300 or more "medically underserved" areas in the United States, over 200 are in Texas. These areas are designated based on four criteria: the number of poor families in the area, the percentage of the population that is 65 years of age or older, the infant mortality rate, and the ratio of primary care physicians to the population.

Clearly, then, a medically underserved area has a population that requires more care because the people are both old and poor yet receive less medical

care than the average community in this country.

Obviously, one solution to the kind of situation that exists in Texas and many other States in this country is to train enough physicians to provide several for every county. We would all like to be able to offer the best quality medical care available to all our citizens. That desire was the basis of the current Medicare reimbursement policy which limits payments it will make only to physicians or to clinics in which a physician is on duty at all times.

However, this reimbursement policy eliminates rural areas of Texas and therefore, many of the old and disabled, from the ability to receive Medicare benefits. In rural areas, the question is not on the quality of medical care but

rather on the existence of medical care.

Mr. Chairman, as you well know, the problems of getting adequate health care delivery in the rural areas has not been entirely ignored. In fiscal year 1977, \$68.8 million was spent by various agencies within the Department of Health, Education and Welfare to promote and pay for innovative approaches to rural health delivery. President Carter, in his budget submission to Congress included \$5 million in this fiscal year and \$25 million in the next fiscal year above current levels for funding of rural health clinics along the line envisioned by S. 708.

However, money will offer no solution unless actual reimbursement policies are expanded to recognize the realities of rural medical practice. We are spending a lot of money, but because of current criteria, large areas of our country are still being left out. That is the problem we are seeking to solve with S. 708. Several of my colleagues on the Health subcommittee of the Finance Committee, to which this bill has also been referred, have joined in co-sponsoring this important piece of legislation. I look forward to our consideration of it.

STATEMENT OF HON. ROBERT DOLE, A U.S. SENATOR FROM KANSAS

While a number of diverse factors contribute to the difficulties experienced by rural Americans in obtaining adequate levels of health care, the manpower shortage is one which is receiving an increasing amount of well-deserved attention. During the 94th Congress, I was pleased to have had the opportunity to testify before a joint hearing between this subcommittee and the health subcommittee of the then labor and public welfare committee regarding legislation designed to attract more physicians to medically-underserved areas.

The emphasis today is upon a different aspect of the manpower question: Namely, of the potential recognition benefits which might result from encouragement of more efficient use of physicians extenders. In my own mind, I feel that there are still several issues to be resolved in terms of the best means for utilizing the talents and services of these individuals. I anticipate that these considerations will be given close and thorough attention when the finance committee takes up extender reimbursement legislation and look forward to participating in that deliberation.

In the meantime, I welcome this opportunity for discussion of the role of physician extenders in our health care systems and of the features of S. 708

in particular.

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STATEMENT OF HON. WALTER D. HUDDLESTON, A U.S. SENATOR FROM KENTUCKY

I appreciate this opportunity to support legislation to permit rural clinics to receive Medicare cost-based reimbursement for services provided by physician extenders and nurse practitioners who provide primary health care under the supervision of a physician. The distinguished chairman (Mr. Clark)

and our colleague from Vermont (Mr. Leahy) are both to be commended for the work they have done already in this area, and for their many other initiatives toward improving the health care available to rural Americans.

It is a well known and well documented fact that health service resources in rural areas are seriously lacking. Almost 50% of all rural Americans live in areas which have been designated by the Department of Health, Education and Welfare as medically undereserved with physician to population ratios worse than one physician for every four thousand residents. In my own state of Kentucky, 65 of our 120 counties, and parts of 10 others, have been so designated. Twenty more will be added to that list if they lose only one physician. In many of these counties, we are talking about physician patient ratios of 1 to 7,400, 1 to 8,900, 1 to 10,100 and even higher. And, as appalling as these figures are, even they understate the problem. They don't reflect how many areas are relying on older doctors who will be almost impossible to replace when they retire. They do not reflect the shortage of other health professionals, or of diagnostic tools and treatment facilities. And, they do not reflect very serious transportation and accessibility problems even in those areas where doctors are present.

One of the most promising solutions to this problem has been the establishment of primary care centers—sort of organized, institutional substitutes for the rapidly disappearing "country doctor," staffed largely by nurse practitioners and physician assistants with back up supervision by a physician. In Kentucky, we have 12 licensed primary care centers—one of which operates 8 satellite clinics—bringing quality health care to areas which otherwise would have to do without. The treatment which they provide, and their emphasis on patient education and preventive services, have made their cost effectiveness legion in many of the areas which they serve—not only in terms of dollars and cents, but also in the very important terms of benefits derived. For example, hospitalization of the chronically ill and the 65 and over age group in the area served by the Frontier Nursing Service operating out of Hyden, Kentucky has been 70–75% below the national average over the past 20 years. In a recent study of 230 diabetics receiving primary care through the service, it was found that the diabetic patient was hospitalized on an average of only 1.6 days in comparison to the national average of 5.4 days. And, only 14% of the ambulatory care was provided by the physician.

But, despite their successes, many of these clinics are threatened with closure as start-up grant assistance from the Department of Health, Education and Welfare and the Appalachian Regional Commission runs out and as they continue to be denied third party reimbursement for services provided by nurse practitioners and physician's assistants unless the physician is physically

present. We cannot let that happen.

The bill under consideration today is not a substitute for efforts to attract and keep physicians in rural and poverty areas—these efforts, too, must be continued and expanded. It does recognize, however, that in many parts of the country we are a long way from realizing the goal of one primary care physician for every 4,000 people. Too, it recognizes that many primary services can be provided by non-physicians under strict guidelines requiring close direction of a supervising physician without sacrificing the quality of health care to which every American must be entitled.

The need for this change in Medicare policy is immediate to prevent the closing of clinics which are the only source of health care in many rural and mountainous parts of the country. I am greatly encouraged by President Carter's earmarking of \$25 million in the fiscal 1978 budget for Medicare coverage of services provided by nurse practitioners and physician's assistants in primary health clinics, and I urge the prompt enactment of authorizing legis-

lation.

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, D.C., April 28, 1977.

Hon. Dick Clark, Chairman, Senate Rural Development Subcommittee, U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: I regret that I was unable to appear before the Senate Rural Development Subcommittee on March 29, 1977, to testify on S. 708, a bill to permit Medicare reimbursement to rural health clinics for primary health services. I greatly appreciate the opportunity to share my views on this legislation with your Subcommittee.

I have co-sponsored S. 708 because it would correct a serious deficiency in the health care needs of rural Americans. Certainly, S. 708 addresses a need of rural areas of my own State of Maryland. The Subcommittee's field hearings in New England and Midwest America revealed similar needs in other areas of the Nation.

The initial impetus to train mid-level health practitioners came from the realization that there are not enough physicians in rural areas to guarantee health

care for all citizens.

Originally, non-physician practitioners were trained to serve as direct extensions of physicians, with the physician serving as the primary decision maker. Training programs for mid-level health practitioners were developed at such prestigious universities as Johns Hopkins, Duke, Yale, Northwestern, Colorado and State University of New York. Excellent programs generate quality products; experience demonstrated that the graduates could provide appropriate

primary care for a high percentage of patients in outpatient settings.

Importantly, non-physician practitioners are also trained to recognize their limitations and to refer to physicians those patients with problems that exceed their competence. It is essential to require that rural health clinics recognize that limitations exist and provide for proper physician participation and referral in order to qualify for reimbursement of the non-physician practitioners' services. Provisions for reimbursement should require that qualifying clinics comply with state laws and regulations controlling the employment and tasks of non-physician practitioners. In the absence of state laws or regulations, the conditions of employment and tasks should be subject to approval by the Secretary of Health, Education and Welfare in order to qualify for reimbursement.

Non-physician practitioners are key elements in our strategy to alleviate serious shortages of primary health care providers. The supply of primary care physicians is particularly short of the needs of Americans seeking health care in rural clinics. S. 708 is vital to meeting the health needs of the people in rural

Maryland and rural America.

Once again, thank you for providing me with the opportunity to comment on S. 708.

With best wishes, Sincerely,

CHARLES McC. MATHIAS, Jr., U.S. Senator.

STATEMENT OF DICK WARDEN, ASSISTANT SECRETARY FOR LEGISLATION-DESIGNATE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

It is a pleasure to be here today to share with you the Department's view on the subject of reimbursement on a cost-related basis for services provided by physician extenders in rural clinics in medically underserved areas.

It is our hope that the Congress will take action to help alleviate the very serious problems in medically underserved areas. We hope later to have the opportunity to testify on this vitally important subject before the Finance Committee, the committee with jurisdiction over the Social Security Act which S. 708 would amend. We appreciate the opportunity to share our views with this Subcommittee as well.

Assuring access to care for residents in rural and other underserved areas is a difficult problem. These areas are often sparsely populated and poor. Currently, about 1,500 of the 3,000 counties in the United States and numerous sub-county areas are officially classified as medically underserved.

More than 20 percent of the population lives in these areas. These people generally have incomes significantly below the national average and infant mortality rates are far higher than those in other parts of the country.

The Department, through its rural health initiatives, the National Health Service Corps, and related health manpower activities, is committed to providing technical and financial support for training and placement of health personnel in health manpower shortage areas. The National Health Service Corps has placed physicians and, in some cases, other health professionals in more than 300 health manpower shortage areas. The recently passed Health Professions Educational Assistance Act of 1976 requires medical schools participating in the capitation program to have at least 50 percent of their filled first-year medical residency training positions in primary care specialties by 1980. The Act also authorizes continued assistance for physician assistant training programs. Regulations being developed under this authority will

encourage special efforts to direct primary care physician assistants into health manpower shortage areas. The Nurse Training Act of 1975 as amended provides traineeships for nurse practitioner students who agree to practice in shortage areas. It has been estimated that, since 1969, \$65 million in Federal funds have been expended to educate and promote the utilization of physician assistants and nurse practitioners in the health care delivery system.

Providing technical and financial support for the training of physician extenders and development of service delivery sites and incentives for health professionals to locate in such areas are not enough. Unless these facilities and professionals can be reimbursed from public and private insurance pro-

grams, they cannot be economically viable in the long run.

In this regard, provisions of the Medicare law have made it difficult for clinics to be reimbursed under Medicare. Clinics have often been unable to obtain Medicare reimbursement for services provided by physician extenders simply because a physician was not on site at all time as required by Medicare.

Over the last three years the Department has undertaken research projects to learn how physician assistants and nurse practitioners affect access to primary medical care as well as the resulting costs and quality of care. Our preliminary findings indicate that these personnel help to redress inequities in the geographic and specialty distribution of physicians, thus improving

access to primary care in rural and poor urban areas.

Mr. Chairman, the Department commends your efforts in this area. We support S. 708. But we would suggest four changes which we believe would strengthen its impact: (a) Allow clinics in all underserved areas to participate; (b) Reimburse clinics for all physician services on a cost-related basis; (c) Retain the Medicare deductible provision for beneficiaries receiving care in clinics; and (d) Allow the Secretary to establish appropriate education and training standards for physician extenders recognized under this reimbursement program.

We believe clinics employing nurse practitioners and physician assistants under general physician supervision, in urban and rural underserved areas, should be eligible for Medicare cost reimbursement. Unfortunately, large numbers of Americans living in cities do not have access to a source of primary care. The Department estimates that of the 45 million people living in medically underserved areas, more than 14 million are urban residents. Given recent experiences with the so-called "Medicaid mills" in urban areas, we understand concerns about extending coverage to clinics in these settings.

It is our opinion, however, that a cost-based reimbursement system with adequate productivity standards, information disclosure requirements, and cost limits can prevent the types of fraud and abuse experienced in "Medicaid

mills".

The Department also proposes to reimburse clinics for the supervisory services of physicians and for direct physician services on a cost-related basis. We believe this approach is preferable to various combinations of cost-related reimbursement for physician services. Cost-related reimbursement would be far more effective from the standpoint of cost-control and fraud and abuse than a fee-for-service method. Additionally, this approach is administratively less complex because it avoids the problem of differentiating between supervision and direct physician services, a problem which has been difficult to solve in the teaching hospital setting.

We do not believe that the Department's approach represents a radical departure from existing physician reimbursement practices. The Department's proposal in no way limits physicians from billing the program on a fee-for-service basis as they currently do. Our proposal merely gives practices utilizing physicians and physician extenders the option of being classified as a "clinic"

and then being reimbursed as a clinic on a cost-related basis.

The Department recommends that the Medicare Part B deductible requirement be retained for beneficiaries receiving services in clinics covered under this bill. While we are aware of the administrative costs of retaining the deductible, it would be inequitable to vary beneficiary cost sharing by treat-

ment setting or place of services.

Finally, we recommend replacing the provision prescribing certification standards for physician extenders with one which would allow the Secretary to develop appropriate qualification standards for physician extenders recognized under this program. We believe that leaving this technical issue to Secretarial discretion would give the bill needed flexibility and the capacity

to respond to changing standards in training and certification of physician extenders. Such minimal Federal standards, of course, would not supersede

more restrictive States standards.

Mr. Chairman, we view legislation in this area as an important and necessary start in promoting access to care for all Americans, regardless of where they live. My colleagues and I would be pleased to answer any questions you or other members of the Subcommittee may have.

STATEMENT OF VERNON WILSON, M.D., VICE CHANCELLOR FOR MEDICAL AFFAIRS, MEDICAL CENTER, VANDERBILT UNIVERSITY, NASHVILLE, TENN.

Mr. Chairman, I appreciate the privilege you have extended to me of submitting this testimony on S. 708, the bill to allow Medicare reimbursement for rural health clinic services. I am Vernon Wilson, a physician administrator, and am currently serving at Vanderbilt University as Vice Chancellor for Medical Affairs.

Most of my professional career has been devoted to educational and service endeavors related to rural health. I am a founding member of the Certifying Board for Family Practice and a continuing member of the American Academy for Family Practice. After receiving my education at the University of Illinois, I had the privilege of serving as Associate Dean and Acting Dean at the University of Kansas and a Dean of the Medical School, Director of the Medical Center and Vice President for Academic Affairs at the University of Missouri. For two and one half years, it was my special privilege to serve HEW under then Secretary Elliott Richardson as Administrator of the Health Services

and Mental Health Administration.

Each of the state universities in which I worked were very active and to some degree successful in their attack upon the problems of rural health care. Vanderbilt University, through the Vanderbilt University Center for Health Services during recent years, has conducted several programs in the area of rural health throughout Tennessee and central and southern Appalachia. The Vanderbilt Student Health Coalition was created in 1968 as a student run organization concerned with health in its broadest sense. For several summers, the students conducted a series of health fairs in various small towns throughout Appalachia. After the first few years of the fairs, it became obvious that a need existed for continuing health care in these smaller towns. In response to this need, twelve communities established health clinics which were maintained year round to serve the residents in these physicianshortage areas.

In addition to the Student Health Coalition, Vanderbilt, through its Allied Health Division and Nursing School, has also operated a series of educational programs designed to train physician assistants. A Family Nurse Clinician program has graduated 41 students since 1971, and an accompanying Primex program has graduated 30 students during its three-year federal grant.

As part of the training of Vanderbilt's medical students, the University has maintained a primary care clinic in Lynchburg, Moore County, Tennessee. The clinic has been staffed by a Family Nurse Clinician during a five day week and by a doctorpreceptor one day each week. This clinic has proved to be successful from an educational standpoint for Vanderbilt and assisted in

meeting the health care needs of rural Moore County.

Dr. Richard Cannon, Dean of the Division of Allied Health Professions at Vanderbilt, has a personal commitment to the concept of physician assistants in rural health care clinics. Dr. Cannon currently is the Chairman of the Committee on Allied Health Accreditation and Education of the American Medical Association. He has also served as the Director of the Middle Tennessee Regional Medical Program, which has provided support for 10 rural health clinics in East Tennessee and two urban health clinics in lower income sections of Nashville, Tennessee. He has therefore witnessed from a programmatic standpoint the health care provided at rural clinics.

With this information as a background, I would like to examine the need for Medical reimbursement at health clinics in Tennessee and throughout rural America. Since such clinics tend to be located in sparsely populated areas, they cannot financially or logistically be staffed by a full-time physician. In the clinics with which I am familiar, they must rely on staffing by nurse

practitioners or physician assistants who work under the general supervision of a doctor. The physician must attend such clinics on a frequent and regular basis and remain on call at all other times. At present, under the Medicare legislation, reimbursement may be provided for costs incurred only while a physician is present on site providing screening, diagnosis, or treatment. This creates a series of difficulties for the clinics and makes professional health

care unavailable for many residents of these areas.

First of all, from the perspective of the senior citizens who are eligible for Medicare, there is a severe financial and logistical strain. These senior citizens are policy holders of the Medicare programs and, therefore, pay a monthly premium. When they receive treatment on a reimbursement basis, they pay a deductible amount out of their own pockets. In rural areas, they quite often are not able to see a physician and must therefore use the services of a clinic. Four days out of five, they must pay for a clinic visit entirely out of their own pocket. In an emergency situation, if the clinic is the only resource available, they still must pay from their own resources in spite of the accompanying costs of membership in the Medicare program. The alternative often is to travel long distances to get care which is often difficult for the young because of terrain and impossible for the elderly because of a lack of transportation.

From the perspective of the clinic, the predominant problem is scheduling of patient visits. Most clinics find the majority of Medicare patients must be scheduled on the day on which the physician is present. Since many elderly people live in these rural areas, this places an undue burden on the clinic during that one day each week. For example, one clinic in East Tennessee sees an average of 40 patients on the physician day and only 20 patients on other days. As a result, many older patients who need not see a physician must do so in order to be reimbursed for the visit. Other younger persons who need to see a physician cannot find sufficient time during his single day at the clinic. Many elderly rural residents simply avoid utilizing the services of the clinic altogether, because of fear of the expenditure of personal resources during an emergency or during four of the five days of service each

week.

From the perspective of the nurse practitioner or physician assistant, Medicare is denying a reimbursement for those professionals whose preparation and training has been funded by HEW in the name of reducing the cost of

health care. This, seems an ironic contradiction in federal policy.

Often when this problem is discussed, the issue of quality of care is of concern. The key is adequate supervision and a clear definition of those activities which are properly addressed by non-physicians. The problems which need referral, in fact, get much more prompt attention. Based upon our experience at Vanderbilt, we can attest that by exercising proper supervision and diligence in the selection of activities undertaken, the standards of care maintained at such rural clinics compares favorably with that in physicians' offices. The physician preceptors who have evaluated the Family Nurse Clinicians, the Primex nurses, and the medical students in the Vanderbilt program have continually been impressed with the standards of care provided by personnel in rural clinics. The Regional Medical Program, whose board includes physicians and nurses and has in the past provided money for these clinics in East Tennessee, its physician members have repeatedly endorsed the quality of care provided at the clinics by continued funding support for the clinics during the history of the RMP program.

The academic literature is replete with examples of excellent care delivered

The academic literature is replete with examples of excellent care delivered at clinics by nurse practitioners and physician assistants. Perhaps the most notable study was conducted by Dr. Walter O. Spitzer and others comparing the primary care treatment received by a patient population from physicians and from nurse practitioners. (New England Journal of Medicine 290:521-6).

Dean Cannon, in his capacity as chairman of the National Accrediting Com-

Dean Cannon, in his capacity as chairman of the National Accrediting Committee, believes that an "acceptable level of care can be maintained" by primary care providers other than physicians. He believes that one method of insuring care is to limit reimbursement to those clinics who employ either legally certified registered nurses who have graduated from an accredited nursing school and/or physician assistants who have graduated from programs which have been appropriately accredited.

Perhaps the best argument in Tennessee for the assurance of a satisfactory quality of care in these clinics is the certification of the clinics for Medicaid

reimbursement by the State of Tennessee. In 1972, the General Assembly of the State of Tennessee enacted legislation which would permit Medicaid reimbursement of health care costs incurred by patients at clinics operating under the general supervision of a physician. It is important to note that reimbursement was to be provided regardless of whether the physician were

on site or available by telephone under emergency situations.

At the present time, of 165 clinics eligible for Medicaid reimbursement, 70 have been so certified and are being reimbursed by the State. Care is being provided by nurse practitioners under the general supervision of physicians. Clinic administrators have found that scheduling problems are reduced and improved care can be delivered through this procedure. Unfortunately, these clinics must still schedule elderly patients, who comprise twelve percent of their present service population, on the particular day in the week in which the physician is present. The clinics maintain a detailed system of formal referrals, both to the clinic and from the clinic to other physicians. Systems must be in place to assure hospital admittance during emergencies, and to refer ill patients to physicians following screening by the nurses. Payment is provided by the State on a fee for service basis. A set of formulas have been devised to determine standard community rates for services performed by physicians. The clinic receives a reimbursement for services performed by nurses based upon a percentage of that fee charged by area physicians for similar

Although no specific studies have been instituted by the Department of Public Health, administrators believe that this reimbursement has reduced hospitalizations in these rural areas. In addition, reimbursement costs for laboratory tests are appreciably lower in the clinics than they are in physicians' offices. Malpractice insurance coverage is carried by the physicians who supervise the clinic; there has been no malpractice litigation since the

program originated.

Although empirical investigations by public health officials have not yet been completed, it is my opinion that the quality of care has improved in rural areas where the clinics are located and where Medicaid reimbursement has been initiated. Many patients who have not previously received health treatments have now been able to do so through the clinic environment. The practice which has proven successful in Tennessee should be considered for use at the national level.

In summary then, our various levels of experience have demonstrated the validity of services provided by rural health clinics and the need for Medicare reimbursement at these clinics. I therefore strongly endorse S. 708 and urge the committee and the Congress to enact this or comparable enabling legis-

lation.

In discussing the elements of these legislative proposals, I would recommend

that five specific points be stressed:

1. Although there are urban as well as rural clinics that could benefit from reimbursement changes, I support your limitation of S. 708 to rural areas only. This focuses the reimbursement upon the most medically needy areas and maintains a concern for the budgetary constraints under which the federal government now operates.

2. It should be emphasized in the legislation, and not left to regulation, that reimbursement will be provided under physician supervision with proper protocols, but that that supervision not be prescribed as a formula for on-site

attendance by the physician.

3. It is recommended that the Secretary be empowered through regulation to determine what training, education, and experience requirements are to be prescribed for nurse practitioners and physician assistants who operate the clinics under the off-site supervision. The Secretary should take into consideration the accreditation procedures for training programs which are described above.

4. Specific quality control processes which emphasize objective peer and patient review of care given in such clinics would be an important addition to the pro-

posed legislation.

5. Finally, I suggest that payment in these areas be on a cost reimbursement basis rather than on a fee for service; in the rural areas so designated by the bill, fee levels under the Medicare program are not sufficient to cover true costs. Additionally, the cost should be calculated and remitted to the clinic

itself as the appropriate administrative and legal entity for proper reimbursement.

I thank you again for the opportunity to present this testimony and wish the committee well in its deliberations.

[The following attachments A-J were submitted by Robert C. Ewell, executive director, Tri-County Health Services Commission, Heppner, Oreg., see p. 30 for his oral testimony.]

[Attachment A]

SUMMARY-TRI-COUNTY HEALTH SERVICE COMMISSION

The Tri-County Health Service Commission is a consortium of three individual counties of Eastern Oregon—Morrow, Gilliam and Wheeler—who have joined together by Memorandum of Agreement to improve the accessibility and availability of health care to their residents by developing an integrated health delivery system, utilizing all available programs and services.

The Commission was first conceived through mutual concern in the early

The Commission was first conceived through mutual concern in the early 1970s by the three County courts, with the initial purpose of the Commission being to search for ways in which to improve health care services to the resi-

dents of the Tri-County area.

In 1972, Wheeler County, which had no previous health manpower, was designated a Critical Health Manpower Shortage Area by the National Health Service Corps, thus qualifying for placement of much needed health professionals.

The first individual to be acquired under this program was a family prac-

tice physician assigned to serve Fossil and the surrounding area.

In 1973, Gilliam County received the same designation as that of Wheeler County. A family practice physician was assigned to Condon under the auspices

of the National Health Service Corps.

In the early part of 1974, the physician who was practicing in the Fossil area elected not to continue his practice once his term with the National Health Service Corps was over. He had decided to locate his practice, instead, in a larger town where in-patient hospital facilities were available. With the departure of this physician, Wheeler County was again left without any health professionals. Relying anew on the National Health Service Corps, we asked for their assistance in recruiting and placement of new personnel. A family nurse practitioner was hired in June of 1974 to fill the void.

In June of 1975, the National Health Service Corps physician working in Condon served notice that he also would not be remaining in the area when his two years expired. Again, a gap was created in our quest to provide adequate health services to the residents of the Tri-County area. To fill this gap, an

additional family nurse practitioner was recruited.

At this time also, one of the two practicing physicians in Heppner indicated a desire to retire. Due to this situation and the unstable conditions of Wheeler County and Gilliam County, a Memorandum of Agreement was signed between the three County Courts to assist each other in their attempts to acquire health services, thus creating the Tri-County Health Services Commission.

The purposes and goals of the present day Commission have previously been explained. The Commission is 100% funded under the Rural Health

Initiative Program of H.E.W.

The effect that this Commission and the Rural Health Initiative has had on the health delivery system in the Tri-County area can be measured in concrete terms.

Two new family practice physicians have been recruited for Heppner. They were attracted to the area by many things, but one of the more predominant being a new clinic that was constructed by the County and supplied to the physicians rent free for the first year, after which time they have the option to purchase at the initial cost.

A third nurse practitioner is being recruited for the Tri-County area. This individual will serve a dual role—as a relief for the current two practitioners

and as a monitor to the home health aide (out-reach) program.

An additional fourth nurse practitioner is contemplated for the northern end of Morrow County which is seeing a great influx of population due to the

expansion of agri-business.

The type and placement of health professionals now serving the area is a direct result of past experience. This experience has shown that physicians are not as able to establish financially viable independent practices in rural areas as a nurse practitioner. As the same time, physicians which serve as a group out of one central location are much more apt to establish such a practice.

We believe that some of the underlying reasons for the increased utilization of nurse practitioners over physician utilization and the higher retention rate is that physicians need in-patient capabilities. Due to the long distances and the poor road conditions from Wheeler and Gilliam Counties to in-patient

facilities, this is impractical.

The Commission is not only concerned with manpower, but the availability

and quality of services.

We have, at the present time, five additional major problems that are being implemented to improve the health delivery system:

1. OUT-REACH WORKER (HOME HEALTH AIDE)

These individuals have been especially trained to go out into homes predesignated by health professionals to provide home health care. Guidelines and policies have been developed that these individuals must adhere to. They are presently monitored by either a physician or a nurse practitioner. When the third nurse practitioner is hired, that individual will monitor the program.

2. RADIO COMMUNICATIONS

Through assistance from the Robert Wood Johnson Foundation, communication equipment has been placed in all of the area's hospital and ambulances to allow for a unified med-con network. Additionally, a paging system is being developed that will allow for more mobility of the health professionals.

3. HEALTH NEEDS

A survey has been developed that will allow us to determine the future needs of the project area. This survey has been distributed to all households in the Tri-County area through the cooperation of Columbia Basin Electric Co-op Company. The purpose of the survey is to determine what the residents want and to match this with current conditions in order to develop a comprehensive plan.

4. LINKAGE WITH THE UNIVERSITY OF OREGON MEDICAL SCHOOL

A project is being developed with the University of Oregon Medical School for placement of student nurse practitioners in the Fossil and Condon Clinics for up to six weeks at a time as a lab exercise. Additionally, a similar type of program is being developed with the family practice resident program.

5. ALCOHOL AND DRUG DETOXIFICATION ROOM

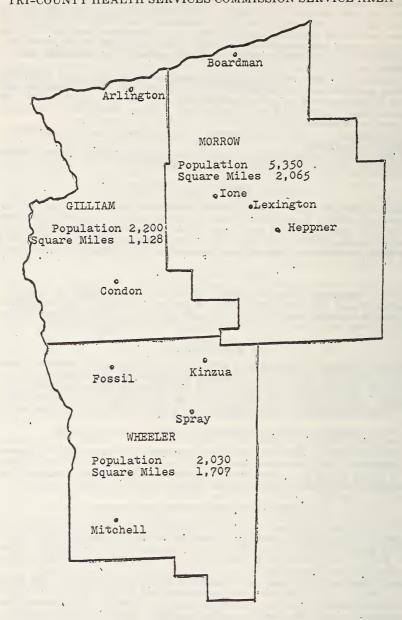
Currently, it is necessary to take individuals who require observation or treatment to Pendleton for admission. Once admitted, it is usually a minimum of thirty days before discharge can be arranged, because of bureaucratic paper work. With the acquisition of a holding room at the local hospital, this current procedure will not be required.

One distinction that needs to be made is that this program is not being totally federally supported, only the Commission, but rather, the large majority of financial support is derived from the counties involved. Both nurse practitioners are/or will be county employees, where they were once National Health Service Corps personnel.

Many problems still remain to be resolved, however, we believe that we have developed a system that is unique in addressing the problem of health delivery in sparsely populated rural areas by utilizing all available resources.

This summary by no means explains the total project, or what has been accomplished. It does, however, present a realistic overview of previous problems and how through local, county and federal support, we have addressed them.

[Attachment B] TRI-COUNTY HEALTH SERVICES COMMISSION SERVICE AREA



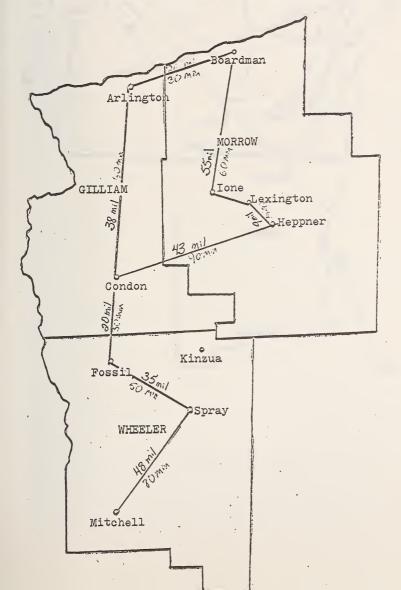
[Attachment C]

Populations-Oregon, 1976

Morrow County	5, 350	Arlington	600
Boardman	800	Condon	930
Heppner	1,650	Lonerock	15
Ione	420	Wheeler County	2, 030
Irrigon	400	Fossil	655
Lexington	245	Mitchell	200
Gilliam County	2, 200	Spray	195

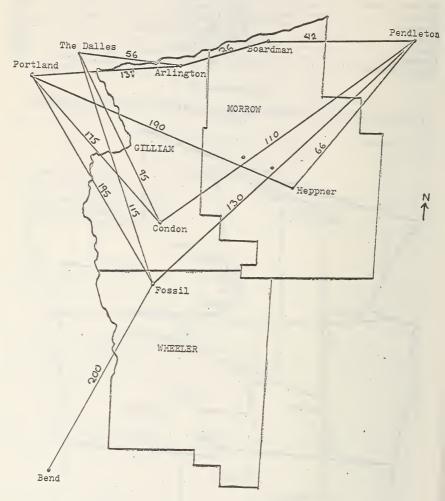
[Attachment D]

TRI-COUNTY HEALTH SERVICES COMMISSION MILEAGE CHART

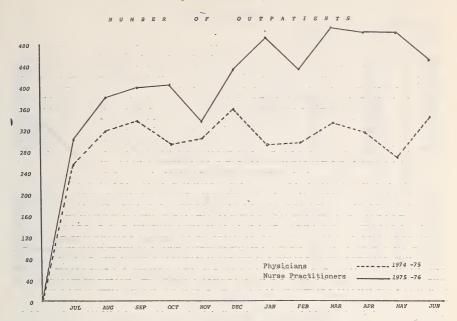


[Attachment E]

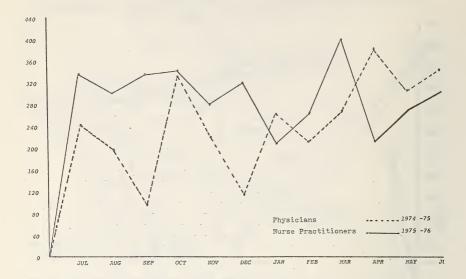
TRI-COUNTY HEALTH SERVICES COMMISSION MILEAGE CHART SECONDARY AND TERTIARY CARE



[Attachment F]



NUMBER OF OUTPATIENTS



[Attachment G] Asher Clinic-Outpatient

	1974	1975	1976
January		215	203
February		271	269
March		410	400
April		221	221
May		269	272
June		299	308
uly	249	399	296
August	199	310	399
September	91	339	327
October	366	343	311
November	217	280	315
December	105	319	336
			
Gilliam County Clinic—Outpatie	nt		
		464	493
lanuary		464 421	493
lanuaryFebruary		421	438
lanuary February		421 498	438 514
lanuaryebruary		421 498 481	438 514 504
lanuary February March April		421 498 481 460	438 514 504 484
lanuary February March April		421 498 481 460 420	438 514 504 484 454
lanuary	255	421 498 481 460 420 293	438 514 504 484 454 390
JanuaryFebruary		421 498 481 460 420	438 514 504 484 454

[Attachment H]

[From the Sunday Oregonian, March 20, 1977]

NW DOCTORS PROTEST-MEDICARE LIST SAID INACCURATE

(By Alan Hayakawa)

A federal report that revealed last week how much Medicare money has gone to certain doctors has caused consternation in the medical community because it contains misleading information.

"There have been some problems with the list," said Mike Naver, press officer for Social Security Administration offices in Baltimore, Md.

He said that a corrected list is being prepared and if any physician feels he is incorrectly listed "he should call that to the attention of the regional office in Seattle."

The complaints have been that doctors serving as part of the staffs of hospitals and clinics receiving Medicare funds were listed as though the physicians themselves were receiving large amounts of Medicare money, rather than the institutions.

In showing that the doctors were the recipients, the computer that com-

piled the list "could have been confused," Naver said.

The figures, released by the Department of Health, Education and Welfare, show that 38 medical clinics and nine physicians in Oregon received more than \$100,000 each in payments for services covered by Medicare in 1975.

But the list, as reported by The Associated Press, names at least three physicians who have little or no private practice and two persons who are not listed as licensed physicians or osteopaths by the Oregon Board of Medical Examiners.

Naver said much of the difficulty with the tabulation arose from the Freedom of Information Act requirement that requested data be made available within eight days. An amendment extending the act's coverage to Medicare took effect March 12, he said.

The list included Dr. Donald S. Crane, a psychiatrist on the staff of the

Oregon State Hospital, although Crane has no private practice.

"They must be talking about the Medicare reimbursements that go to the state for patients I treat at the hospital," Crane said.

Robert Dernedde, executive director of the Oregon Medical Association, said the association had checked many of the figures on the list and was finding "no relationship whatsoever" between the alleged Medicare earnings and doctors' actual receipts.

Nationally, the American Medical Association was finding an accuracy rate of less than 30 per cent for the Social Security Administration's figures, Der-

nedde said.

The Oregon Medical Association planned a strong protest to the state's

congressional delegation, he said.

Naver said two persons listed as physicians in the AP report are not mentioned in the original Medicare list. He said he did not know where the names, "Raymond F. Mann" and "D. Sandnald," came from. The Board of Medical Examiners had no listings for the two under the spellings given by the AP.

Two Portland neurosurgeons, Anthony Gallo and Errett Hummel, were listed as receiving more than \$250,000 between them, although their office said their

private practices are very small.

Both Gallo and Hummel are on the University of Oregon Health Science

Center neurology staff.

Linda Doherty, administrative assistant in the Portland Social Security office, said there were several reasons some physicians and clinics might attract more Medicare business than others.

Location near urban areas where large concentrations of elderly persons live is one reason, she said, noting only persons over 64 or those who have been receiving disability payments under Social Security for two years are eligible for Medicare.

The willingness of physicians to accept "assignment" of Medicare payments and to help patients fill out complex claim forms is another reason Medicare

clients might choose one doctor over another, she said.

Doctors with a geriatric specialty also attract older persons, Ms. Doherty said. Such specialties include eye surgery such as for cataracts, vascular surgery for the circulatory deterioration associated with aging, heart disease, cancer, orthopedics (broken hips occur commonly among seniors), and urology.

A clinic may have larger Medicare billings simply because of its size (some have 30 or more doctors), and also because an association of several doctors may be better able to afford the clerical help needed to file Medicare claims, she said.

[Attachment I]

HEALTH SERVICES PROVIDED

Services provided by Family Nurse Practitioner.

1. General medical physical examinations.

2. Treatment of general medical problems.3. Well-baby care.

- 4. Uncomplicated pediatric problems.
- 5. Immunizations.
- 6. Minor Surgery.
- 7. OB-GYN care.
- 8. Family planning.
- 9. Referral to specialists in the area.
- 10. Obtaining necessary laboratory tests.
- 11. Treatment at area hospitals.
- 12. Emergency services (will include but not limited to): (a) Minor trauma, (b) lacerations, (c) simple fractures, (d) heart attacks, (e) major trauma, (f) respiratory distress, (g) seizures, (h) O.D.'s, and (i) stabilizations and

transfers to appropriate medical center.

13. Laboratory services to be done in the clinic: (a) routine urinalysis, (b) hemorcult, (c) CBC, (d) hermatocrits and sedimentation rates, (e) blood glucose levels, (f) pregnancy testing, (g) bacteriology, (h) EKG, (i) pap smears, (j) X-Ray services—chest and extremities, and (k) other routine blood tests will be done at the clinic and sent to Inter-Path Lab in Pendleton for analysis.

[Attachment J]

OREGON STATE BOARD OF NURSING

ADMINISTRATIVE RULE FOR THE EDUCATION, PRACTICE, CERTIFICATION, AND CONTINUING EDUCATION OF NURSE PRACTITIONERS IN AN EXPANDED SPECIALTY ROLE

Standards for accreditation of educational programs in nursing preparing candidates for certification as a nurse practitioner.

A. Definitions

"Institution of Higher Learning" means a four-year college or university.

B. Organization and administration

1. Shall be located in an institution(s) of higher learning.

2. Shall, by January 1, 1981, carry credit toward a master's degree in nursing.

C. Philosophy, objectives, and curriculum

1. Philosophy shall reflect commitment of faculty to concepts of adult learning and to problem-oriented teaching and patient management.

2. Objectives shall be stated in behavioral terms and describe minimal com-

petencies for each course and for total program.

- 3. The curriculum shall be a specialized in-depth education in one or more of the specialty areas designated in these rules: (a) Be at least one (1) academic year which includes theory and practice. (b) Include content in the following areas—(1) Patient assessment, including lab and other diagnostic procedures appropriate to the clinical specialty areas. (2) Analysis of data and problem identification. (3) Development of management plans, including further diagnostic studies, therapy, patient education and identification of parameters for follow-up. (4) Modification of management plan based on new patient data and/or new information regarding appropriate management of identified problems.
- A. Application requirements for initial certification as a nurse practitioner in a specialty area

1. Current license as a registered nurse in the State of Oregon.

2. Evidence of having satisfactorily completed a certificate or degree program appropriate to the specialty area and approved by the Oregon Board of Nursing or a program in another U.S.A. jurisdiction or foreign country equivalent to that required in this state. Evidence of satisfactory completion of such a program in this state, another state or country shall be an official transcript, showing all courses, grades, quality points, degree or diploma granted, official seal and appropriate registrar's signature, received by the Board directly from the program.

3. If more than two (2) but less than five (5) years have elapsed since

3. If more than two (2) but less than five (5) years have elapsed since completion of the educational program and the applicant has not practiced in an expanded specialty role during that time, the applicant shall meet the requirements above and provide documentation of one hundred (100) clock hours of continuing education related to the specialty area for each biennium applicant has not practiced in the expanded role. The Board may require evidence of current clinical competency in the specialty area as determined

by professional performance review.

4. If more than five years have elapsed since completion of the educational program in the specialty area and the applicant has not practiced in an expanded specialty role during that time, the applicant shall: (a) Obtain a license as a registered nurse in the State of Oregon. (b) Complete a minimum of 240 hours of supervised clinical practice* in the appropriate specialty area. (c) Submit a satisfactory professional performance review in the appropriate specialty area.

5. As of January 1, 1981, a nurse applying for initial certification shall have a minimum of a baccalaureate degree with a major in nursing plus satis-

factory completion of an educational program in the specialty area.

^{*}Clinical experience under the direct supervision of a physician or nurse practitioner practicing in the same or related area.

6. As of January 1, 1986, a nurse applying for initial certification shall have a master's degree with preparation in the specialty area in which expected to practice.

7. Payment of fees required by the Board.

B. Notification of change of practice

Change in practice status or settings shall be reported to the Board no later than 30 days after the change.

C. Renewal of certification

Shall be consistent with the current renewal system of the registered nurse as prescribed by the Board prior to the expiration date set forth in ORS 678.101 and shall be dependent upon: 1. Current license as a registered nurse in the State of Oregon. 2. Documentation of continued clinical competencies by professional performance review.

3. Documentation of a minimum of one hundred (100) clock hours of continuing education related to the specialty area to be submitted on or before 12:01 April 1, 1979 and every biennium thereafter. (See Administrative Rule

851-30-217). 4. Payment of fees required by the Board.

D. Delinquent renewal

PROFESSIONAL PFRFORMANCE REVIEW

A. Definition

Professional performance review is the process by which a physician or nurse practitioner, actively engaged in the practice of medicine/nursing in the same or related specialty area, evaluate the quality of patient care provided by individual nurse practitioner according to established standards of practice.

B. Professional performance review team

1. Composition of Review Team: One physician and two nurse practitioners or three nurse practitioners.

2. Identification of Review Team: (a) Selection by the nurse practitioner.

(b) Assistance from the Board of Nursing.

C. Process for professional performance review team

1. Performance shall be evaluated in relation to: (a) Scope of practice as set forth in these Administrative Rules. (b) Standards of practice for safe and effective care in the specialty area accepted by the nursing profession.

2. Results of Professional Performance Review shall be reported on a form supplied by the Board. Negative evaluation shall have documentation attached.

3. Negative evaluations submitted shall be subject to process described in

3. Negative evaluations submitted shall be subject to process described in ORS 678.111 (2).

THE ROLE OF THE NURSE PRACTITIONER IN AN EXPANDED SPECIALTY ROLE

A. Definitions

As used in these rules:

1. "Practice in an expanded specialty role" or specialty area means clinical practice based on specialized education which prepares a registered nurse to

provide primary health care.

2. "Primary health care" means care which may be initiated by the client or provider in a variety of settings. The nurse practitioner is primarily responsible for the provision and management of a broad range of personal health services which may include: (a) Promotion and maintenance of health. (b) Prevention of illness and disability. (c) Management of health care during acute and chronic phases of illness. (d) Guidance and counseling of individuals and families. (e) Referral to physicians and other health care providers, and community resources when appropriate.

B. Categories of specialty areas may include but are not limited to

- 1. Family Nurse Practitioner.
- 2. Pediatric Nurse Practitioner.
- 3. Adult Nurse Practitioner.
- 4. Geriatric Nurse Practitioner.
 - 5. Psychiatric/Mental Health Nurse Practitioner.

- 6. Nurse Midwife.
- 7. Women's Health Care Nurse Practitioner.8. School Health Nurse Practitioner.
- 9. College Health Nurse Practitioner.

C. Scope of practice

In addition to the services provided by the registered nurse, the nurse practitioner is authorized to provide management of mental and physical health care in the applicable specialty area, the scope of which shall be based upon educational preparation, continued experience and the accepted scope of professional practice of the particular specialty area. Such management is to be provided through integration of health maintenance, disease prevention, physical diagnosis, and treatment of common episodic and chronic problems, including pregnancy, in primary health care in collaboration with physicians and other health care professions and agencies.

D. Violations

Nurse practitioners are subject to disciplinary actions as set forth in ORS 678,111.

PIONEER MEMORIAL HOSPITAL

	Patients admitted	Patient days	Outpatients
974:			
July	38	124	91
August	39	252	102
September	33	156	7
October	23	115	4
November	31	193	51
December	32	244	9
975:			
January	42	307	10
February	57	294	9
March	35	268	9.
April 1	28	186	160
May	47	186	199
June	44	191	17
July 2	40	138	21:
August	63	241	23
September	45	161	20
October	65	170	25
November	73	267	19
December976:	69	307	20.
January	52	212	19
February	65	245	224
March	79	280	320
April	80	210	27
May	46	232	234
June	50	244	30
July	80	280	26
August	66	210	25
September	34	115	26
October	60	273	25
November	82	242	23
December	77	240	263
1974 to 6 mo	196	1, 084	474
1975	608	2, 716	1,090
1976	771	2, 716 2, 733	3,060
		Percent increases	
	1975/1976	1975/1976	1975/1976
anuary	+124	-145	+188
ebruary	+144	-120	+249
March	+226	+106	+340
April	+286	+113	+173
May	+98	+119	+118
une	+114	+128	+221
uly	+105-+211 +162-+169	+111-+226	+218-+270
lugust	+102-+109	+105-+120	+225-+246 +267-+339
eptember	+136-+103	+103-+136	+267-+339 +604-+598
october	+283-+261	+148-+237	+004-+598

^{1 1} new physician practice.

² 2 new physicians practice.

STATEMENT OF EUGENE C. CORBETT, JR., M.D., CENTRAL VIRGINIA COMMUNITY HEALTH CENTER, NEW CANTON, VA.

The remarks which follow relate to the proposed legislation which would allow for the reimbursement of physician extender services under Medicare Part B (S. 708). I will contend that the proposed legislation is a step in the right direction and sets a good precedent for establishing alternative means for providing health care, particularly in rural areas. My discussion will focus on the reasons for the legislation as well as some specific aspects of nurse practitioner use. In addition, I include a suggestion for altering the legislation to provide reimbursement for physician extender services irrespective of the geographical location.

I am a General Internist, city-born and raised, now living in rural Virginia and working within a Community Health Center. My interest in working in an area where there was a need for medical services brought me to the country in 1970. I was attracted to the country by my introduction to rural life and to the prospect of working within a rural Community Health Center.

The Central Virginia Community Health Center was originally funded by O.E.O. in 1970. The Center currently receives grant support under Section 330 of the Public Health Service Act by the Bureau of Community Health Services, D.H.E.W. The Health Center provides a comprehensive range of health services and is the major medical provider for a three county, 1,200 square mile area. This area has a population of 25,000, approximately 60% of whom have used the Health Center facilities since its establishment six

(6) years ago.

The population is quite evenly disbursed over this area, the largest concentration of people being in a town of four hundred and fifty (450). About one-third of the population have incomes below the poverty level. Eleven and a half percent (11.5%) of the people in the area are sixty-fire (65) years of age or older and one-third are over the age of forty-four (44). No public transportation exists in the area and many families have no personal means of transportation, particularly to the distant urban Medical Centers. More than forty percent (40%) of homes in the area have no flush toilets and more than thirty percent (30%) have no running water. The infant mortality rate is above the national average. In addition, because of the lack of jobs and industry in the area and the declining viability of small farms, young adults tend to leave the area during their productive years leaving many families composed of young children and older aged individuals. (Demographic data source: 1970 U.S. Census)

The number of rural solo practitioners in the area continues to dwindle. At the present time there are three solo practice physicians in the area of whom only one (1) practices full time. Only one (1) of these physicians is less than sixty-five (65) years of age. The only other medical facilities within reach are those found in the distant cities forty to seventy (40–70) miles

from New Canton.

The Health Center staff includes six (6) full-time physicians and seven (7) full-time nurse practitioners. They work in teams, composed of a physician and nurse practitioner, which are generally responsible for specific geographical sub-sections of the service area. The comprehensive range of services provided includes acute and chronic disease care, preventive health services, family planning services and home health services under the supervision of the team physician and nurse practitioner.

Health services are provided at five (5) locations. The main center includes facilities for laboratory, x-ray, pharmaceutical, dental and other support services and is centrally located in the three-county area. The four (4) satellite clinics are located within a twenty (20) mile radius of the main Health Center. Satellites are staffed three (3) days a week by nurse practitioners and one (1) day a week by the team physician. Services have been provided at these satellites since 1972 by nurse practitioners. The care so provided is reviewed by the team physician although he is not physically present at the time these services are delivered by the nurse practitioner. Each satellite has protocols for the treatment of a variety of common adult and pediatric illnesses and for health maintenance procedures performed for children and adults. All visits are recorded using a problem oriented medical record. In addition, the Center has an on-going quality assurance effort and appropriate

pharmaceutical administration and procedures. Both phone and radio contact are available between the satellite facilities and the main center for con-

sultation between the physician and the nurse practitioner.

I should mention that as the years have gone by since 1970, staff turnover among the physicians and nurse practitioners has tended to stabilize so that there is a considerable amount of familiarity and confidence among the professional staff.

EFFECT OF THE PROPOSED LEGISLATION

The Health Center relies on the comprehensive grant funding from D.H.E.W. for the bulk of its revenue. The Public Health Service Funding Regulations rightly rquire that Community Health Centers, like ours, make every effort to obtain third-party reimbursements for the services we provide. The Health Center currently has its non-reimbursed costs covered by our D.H.E.W. grant, but those funds are steadily shrinking in the face of rising costs and cannot reasonably be relied upon forever. Our Center's inability to obtain reimbursement for medical services provided by nurse practitioners at satelite clinics under Medicare and Medicaid (except EPSDT) place the viability of those facilities in question.

This legislation would allow us to bill Medicare for an additional \$17,000-\$25,000 annually for mid-level practitioner satellite visits. While this amount alone would not insure the continuation of these services, it would help fill a serious financial gap. Such reimbursement would be most welcome and quite frankly is past due. We also hope passage of this legislation will set a precedent soon to be followed to allow for Medicaid reimbursement, and hopefully other health insurance sources. Paying patients already are billed for and pay for nurse practitioner services, including non-directly supervised

care.

WHY THE PROPOSED LEGISLATION MAKES SENSE

There are three major reasons why S. 708 makes sense: (1) It would recognize and encourage the provision of care in the community which might otherwise be provided in the hospital. (2) It would allow the physician to spend more time with the more complex and serious illnesses while allowing him to delegate more responsibility to the nurse practitioner for less complex forms of care. (3) It would allow for the reimbursement of a needed medical service and would lessen the emphasis on the physician as the provider of care.

For a variety of reasons rural residents are not necessarily hospitalized at the same rate and for the same sorts of illnesses as urban residents. Many rural patients do not wish to go to a distant city for care. In addition, many illnesses for which a patient would be hospitalized in the city can be cared for as well and more conveniently at home if there is proper medical attention and follow up capability. This kind of practice became familiar only as a result of my experience in the country—it was not something I was taught in

medical school.

Medicare will reimburse for the care of most illnesses if patients are hospitalized. It is unfortunate that such care is not as easily paid for when brought out into the community. With the assistance of a nurse practitioner and perhaps a home health aide, a physician in the country can provide for the care of a mildly unstable diabetic or the patient with mild heart failure distant urban medical complex. It seems ironic that if a patient were hosat least as well as it might be cared for if the patient were sent off to a pitalized, the Medicare reimbursement would include the cost of non-physician and physician services. This legislation makes sense because it recognizes and financially supports such care being provided in the community.

The desirability and often the necessity of in-community care for the patient

needs to be recognized. As a practicing rural internist I could relate to you many instances in which I sent a patient with such an illness home after having arranged a care plan and follow up with the assistance of my nurse practitioner and a home health worker. I know from my training and experience in the city, that had the same patient been seen in an urban setting, they would more likely have been hospitalized for the acute phase of that illness. For the rural physician to be able to provide in-community care with as much assurance of the benefit to the patient, he needs help. The nurse practitioner is invaluable in delivering such care.

In our attempts to bring this care out to rural patients, we are limited by our inability to obtain financial reimbursement for these services even though the cost would be much higher if the patient were hospitalized. Failure to recognize and act on this fact is a failure to correct an easily identifiable

factor in any cost-containment effort.

Secondly, through the use of nurse practitioners the physician has more time to spend with patients so that a higher quality of service can be provided. The saga of the rural solo physician providing acute care but having little time for much else is well known. Much of the reasons for my own venture into the country was the recognition that my skills in providing more comprehensive care could be realized when the rural setting included an appropriate and well-equipped facility and the assistance of other health professionals including the nurse practitioner.

I want to point out that doctors and nurses have always worked well together in the hospital and in this setting provide a more comprehensive care effort for a patient than if the physician had to work alone. In the ambulatory setting as well—especially in the country—the physician can use assistance in the provision of quality services which necessarily includes other than acute care. (Preventive health care, chronic disease management, family planning, etc.) With the assistance of a competent nurse or other physician extender

such a type of practice becomes possible.

The third reason why this legislation makes sense is because it would enable us to focus more on the type of care provided than on the type of practitioner providing that care. What seems important here is that care is given which is competent and appropriate to the health or disease state of the patient. It is less important who provides the care. Traditionally we seem to have focused more on who provides care and on paying doctor bills rather than looking at what care is provided and paying the patient bill. What I am saying is that as long as the patient with a urinary tract infection or hypertension is treated appropriately, such a service should be equally reimbursable regardless of whether a doctor or a nurse practitioner actually performed the service. As long as the practitioner is competent and observes appropriate standards of care, it is not necessary for them to be under the same roof as a physician. It has never been required, nor is it necessary, that the hospital physician remain within shouting distance of the caring nurse. Similarly it is also not necessary for the rural physician to remain within shouting distance of the physician extender.

THE QUESTION OF QUALITY

Considerations regarding quality of the care provided include those that relate to the individual competence of the practitioner and those that relate to the care provided by that individual. Traditionally, the competence of the individual in medical practice has been based upon the completion of an accredited program followed by a State and/or National licensure or a board certification. I see no reason why the same stipulations applied to the physician extender would not guarantee a similar degree of competence of the physician extender as it does the physician. Although there may be questions about how well such stipulations guarantee the competence of the individual practitioner, this consideration applies to physicians as well. It would be appropriate for purposes of this legislation to require that the practitioner have completed an appropriate training program and received licensure and/or certification. I don't believe it is necessary to apply a different standard to the physician extender than is already applied to physicians.

Regarding the quality of the actual care provided to the patient, measures should be taken to assure that the services are of appropriate quality. In our own setting this effort is a continuous process which takes place between the team physician and the nurse practitioner. The physicians generally review all of the clinic notes of the nurse practitioners and meet with them at specific intervals to review problems and other care aspects. Quality assurance efforts include periodic chart reviews for the care of various medical conditions by both physicians and nurse practitioners. In addition, when physicians and nurse practitioners work together over a period of time, par-

ticularly when staff turnover is minimal, a considerable amount of understanding with regard to standards of care develops between the practitioners.

With respect to this piece of legislation, the requirements that clinics or individual practitioners should meet in order to qualify for Medicare reimbursement are adequately stated in the language of the proposed bill. I would like to emphasize what I consider the most important requirements:

1. That the physician extender have a definite link to a physician for con-

sultative, referral and care review purposes.

2. That the physician be available to the physician extender whenever the

physician extender requires assistance.

3. That some written documentation exist regarding the standards of care and other aspects of clinical practice as well as procedures regarding the handling of drugs and the procedures for care review.

4. That a standard medical record be maintained.

MANNER OF REIMBURSEMENT FOR SERVICES PROVIDED

It would seem most sensible to have a reimbursement schedule which reflects the cost for providing service irrespective of which practitioner provides it. This is based on the assumption that care of equal quality is provided by the physician and the physician extender. If the individual physician employing a physician extender or the clinic which employs a physician extender has met the basic requirements for receiving reimbursement, it would seem most appropriate to have the reimbursement made to the physician or facility for whom the physician extender works. The reimbursement mechanisms need not be any different than already exist for the reimbursement of physician care.

NURSE PRACTITIONER-PHYSICIAN RELATIONSHIP

In our setting the nurse practitioner provides the bulk of well baby care, a good portion of prenatal care and family planning service, adult and child health maintenance care, episodic illness care in children and adults, and assistance in the management of chronic and stable medical illnesses of adults. The physician, on the other hand, is more involved in the diagnostic and therapeutic aspects of illness care and in establishing the overall stand-

ards of illness and preventive health care.

In my own practice I work with a family nurse practitioner. With her I share a patient load that I believe is larger than that which I could handle as well alone. Often she will see patients when I am not immediately available, or she might see them at the satellite facility in some follow-up capacity. For example, there are a number of patients with simple hypertension, diabetes or pulmonary disease whose therapeutic regimens have been established and their course is stable. Rather than my having to see the patient two or three times a year, I may only need to see them once if they are doing well. My nurse practitioner knows how to evaluate the state of their condition and is quite competent to detect changes in their clinical status. There are explicit as well as many informal aspects of caring for such patients which she understands well having worked with me for eighteen (18) months, In addition, I generally make it a point to let patients know that they have both a physician and a nurse together to provide for their care. When approached in this fashion most patients are quite understanding and satisfied. In this way I can provide care to a larger number of patients than I would if I had to see each one myself every time. Another instance in which the nurse practitioners' skills are quite helpful

is when I am unable to find time in my appointment schedule for a patient, For example, a patient with mild congestive heart failure who is improving can be seen by the nurse practitioner, and often seen at the satellite facility which may be more convenient for the patient as well. The care of the healthy young woman in family planning services is another example in which the nurse practitioner is quite competent and can therefore reduce the physician load, since this is an area of care in which standards of practice are easily made explicit and for which protocols are established. These are just a few of the many instances in which the care provided to an individual is more complete or becomes more available as the result of having a nurse practitioner assist in the provision of the care.

OF SPECIAL NOTE

An important and very interesting situation arises as a result of this legislation. At the present time if a physician finds himself at the limit of his practice insofar as his caseload is concerned, his only alternative is either to curtail additional practice and refuse new patients or to add physician manpower to his efforts. With legislation such as S. 708, however, another alternative becomes possible—that is to add a physician extender or nurse practitioner to his practice. If a physician extender is used in the kinds of situations I have previously described, this becomes a very real and, to my mind, appropriate alternative for increasing the health manpower of a practice.

I want to emphasize this feature since I believe it would be inappropriate and overly restrictive to create a law which states that an individual who has a capability of providing a certain type of service can do it only in a rural area. Rather than becoming a more permissive piece of legislation it would become more restrictive. If an urban physician needed to expand the manpower of his practice he currently can either add other physicians to his group or hire a physician extender. But in this latter case he is required to be physically present at all times. Under present law most physicians prefer increasing their health manpower by using additional physician alternatives. Thus the increased demand for more physician manpower remains mandatory. Perhaps one of the reasons we have such a predominance of physician manpower in urban areas is because the physician is not forced to look outside of the city, there always being a need within the city, even in more physician-populated areas.

My own opinion is that the current health manpower pool, including physicians as well as the various types of extenders could easily satisfy the health care needs of this country. If this large physician extender pool were to be legitimized by removing the current reimbursement restrictions, whether urban or rural, it might impact on some of the health manpower needs in the cities so that the demand for urban physicians would be less. We need physicians as well as physician extenders in the country. I don't believe that having legislation which allows for rural physician extender reimbursement will necessarily increase this pool of the rural physician extenders to a great degree. If urban physicians were able to use more independently the services of competent physician extenders perhaps physicians who would otherwise

settle in the cities would consider more rural settings.

In closing I want to emphasize that from my point of view as a practicing physician, this legislation makes a lot of common sense both financially and from a practice point of view. It allows for the physician to use non-physician alternatives for providing care to people and within a practice can free him up to concentrate more on the diagnostic and therapeutic aspects of care. By allowing the physician to share caring aspects with a variety of health professionals who are competent and well trained, the quality of services provided by that physician seems more assured. My own experience suggests that patients find this easy to accept. When they know that the physician extender works with the physician they don't seem to have much of a problem and often are as pleased by the result. As long as appropriate measures to insure the competence and quality of service exist, this alternative seems less costly. Most importantly, this approach is an attempt to bring patients and health professionals out of the hospital and into the community.

As a health professional I believe that the legislation would tend to give credence and legitimacy to the caring potential of a variety of health professionals. I am talking here about an evolution from an in-hospital model of medical care to a community model of general comprehensive care in which the doctor and nurse together with other health professionals can provide for the care of patients. In rural America in particular it seems less likely that patients will be hospitalized for illnesses than if they were in

the city. Many of these illnesses can be cared for as well and as competently in the country if the physician has help from others. We need to try to diminish the restrictions which exist in our current system of reimbursement which almost universally require that the physician provide the service. Although physicians should set the standards of care so that they are consistent with the basic science of the human body and mind, it is not necessary for the physician to provide all the care himself. This has never been true in the hospital setting; it does not need to be true in the community setting either.

We need to move toward encouraging a health system which allows for those who can care for people competently to do so irrespective of credential or degree yet with proper safeguards for assuring the quality of the service delivered. The establishment of legislation which provides for the reimbursement of services under these conditions would be a step in the direction of

more appropriately using the health manpower that we have.

STATEMENT OF DAVID E. WALSTON, PHYSICIANS' ASSISTANT, SOUTH PLAINS HEALTH PROVIDER ORGANIZATION, INC., PLAINVIEW, TEX.

I appreciate the opportunity to testify before the Sub-Committee on the need for changes in the current Social Security Act, public law 92-603, re-

garding reimbursement for medical services in rural areas.

I am a graduate of the University of Texas Health Science Center at Dallas, Physicians' Assistant Program and certified by the National Commission on Certification of Physicians' Assistant. I have been employed by South Plains Health Provider Organization, Inc. for the past seven months as a practicing physician's assistant.

Because of the vastness of our nation and the distribution of our population, a serious problem has arisen to which we must turn our attention. This

problem is the inaccessibility of health care in rural areas.

The South Plains Health Provider Organization has alleviated that problem for over 16,000 patients in the Texas Panhandle many of which are medicare eligible. Since its creation in 1973, we have provided quality medical care for those living in the HEW designated medically underserved rural areas of northwest Texas. In the three years of our existence, our patient rolls have increased dramatically, necessitating an increase in the staffing of our facilities. In order to meet the needs of our patients, it has become necessary to utilize the physician extender as a primary care provider. We currently employ two licensed nurse practitioners and two certified physicians' assistants in addition to our three full-time physicians.

TOTAL HEALTH CARE OF MEDICARE PATIENTS

With the addition of each new medicare patient, the organization assumes the responsibility for total patient care. It is well known that elderly patients often suffer from multiple health problems, all of which must be attended to and evaluated to insure quality health. The threats of cancer, diabetes, heart disease and hypertension become more severe in the older age group. These health problems require constant evaluation and screening if early detection and adequate treatment are to be our goals. It is not conceivable that physicians can provide all these services in the rural areas without the assistance of physician extenders. Each medicare patient in our organization is currently being seen an average of two to four visits per month, for periodic blood pressure checks, medicine refills, and follow-ups for chronic illnesses.

These patients would place an unbelievable burden on our physicians, were not physician extenders utilized. This type of medical care is essential for these patients if their health is to be sustained. In the area served by the South Plains Health Provider Organization, this type of total patient care is either not available or not affordable. In addition, most of the private physicians are unable to see new medicare patients because of the complexities of reimbursement and their already over-inflated practices. The

elderly or disabled in our communities and in our nursing homes are being deprived of health benefits readily available to persons in more urban areas. This deprivation is based largely on the fact that physicians are not available and physician extenders cannot function in the capacity for which they are trained. If physician extenders were reimbursed by Medicare our outreach could improve dramatically and services would be more accessible to the patients.

PHYSICIAN AND PHYSICIANS' ASSISTANT PATIENT ACCEPTANCE OF PHYSICIAN EXTENDERS

A major concern has been voiced by physicians and physicians' assistants alike. That concern is patient acceptance of the mid-level practitioners. Since the earliest utilization of physician extenders in private practices, the testimonies of countless physicians have proven beyond a doubt that patients in every office or clinic setting are willing to be seen and treated by either a physicians' assistant or a licensed nurse practitioner. Only rarely does a patient specifically request a physician. The patient acceptance of their ability, training and judgment are beyond question. In many cases, the patient specifically requests the physician extenders, simply because they receive more personal care and consideration than from the busy physician.

In addition, the question has arisen concerning the professional relationship between physicians' assistants and physicians. Here again, experience speaks for itself. In most cases, the health care team functions smoothly and with the highest regard for each others training and skills. Both the physician and the physician extender recognize each other's role and limitation without conflict. The physician and physician extender often find this relationship to be a symbiotic one, in which both expand their knowledge of medicine based on each others skills and sharing of ideas. Through this process, they con-

tinually improve their methods and expand their knowledge.

though their monthly contribution is made to Medicare.

INCONSISTENCIES WITHIN THE PRESENT POLICY

The current policy of failing to reimburse physician extenders for their services to our elderly and disabled demonstrates certain inconsistencies and irregularities worth noting. In 1973, the Department of HEW awarded \$6.2 million to 36 institutions of higher learning to train physician extenders for primary care tasks. Many of these trained individuals are currently serving in remote areas which were once medically deprived. Thousands of rural Americans now depend on their skills. In addition, it is projected that based on future legislative approval, \$90 million will be spent to fund physicians' assistant programs nationwide as part of the Health Manpower Training Act. The goal of such funding is to place physicians' assistants in designated Health Manpower Shortage areas. It is a paradox to note that while mid-level practitioners are trained by federal dollars, their services go unsupported.

The present medicare policy of our government discriminates against a large segment of our elderly population. These medicare eligible recipients pay their monthly premium for medicare benefits but receive no health care because physicians are not available. Our medicare patients must travel long distances at their own expenses to find professional medical care. Many elderly and disabled patients must do without the services that are readily available in urban areas simply because a greater concentration of doctors exist in urban areas. Medicare patients in rural areas do not receive equal health care,

It is also worth noting that other government agencies widely utilize physicians' assistants to treat veterans in our Veterans Administration hospitals and in the U.S. Public Health Service Corps. The Civil Service Commission has, within the last two years, established a separate category for Physicians' Assistants in government service positions. The importance of their role in primary medical care is beyond question. In addition, Medicare presently authorizes repayment for services rendered to patients seen, examined, and treated by the Home Health Agency, a federally funded program in which such services are provided only by registered nurses. Such nurses are reimbursed

by Medicare in the amount of twenty dollars for each home visit in rural West Texas.

> IMPACT OF THE PRESENT POLICY ON SOUTH PLAINS HEALTH PROVIDER ORGANIZATION, INC.

It is impossible to know the full impact of the present lack of physician extender reimbursement on the South Plains Health Provider Organization. As our medicare patient population increases to its projected level, our facilities will experience the impact. Physicians' assistants and nurse practitioners represent the most cost effective means of providing health care for our elderly. While it is not possible to provide physician coverage for each rural community of our area physician extenders can provide low cost quality health care. Through our vast communications network each mid-level practitioner is only seconds away from the professional advice and consultation of his or her supervising physician. Such practices are currently in use in our area and even more extensively in other states such as New Mexico and Oklahoma. The Playas Telehealth System is one such example where physician extenders are linked to physicians through an interactive television link. Other such are linked to physicians through an interactive television link. Other such projects are currently in operation to improve rural health availability. The success of these operations cannot be guaranteed without proper reimbursement for medicare patients. Some are currently under investigation by the federal government for improper and unlawful medicare payments.

The South Plains Health Provider Organization is presently considering

expanding our services to include other rural communities. One such community is Olton, Texas, where a town of 2500 population are without the services of a single physician or nurse. Presently, the city supports a completely supplied clinic facility but has no one to provide medical care. The citizens must travel 30 miles to find professional medical assistance. The South Plains Health Provider would be able to expand their services to Olton and other such rural settings if physician extenders can be utilized legitimately and in compliance with the medicare policies. Most rural communities are without hospitals in our areas and emergency treatment is not available. When time can mean a life or death situation, a health facility can be an invaluable commodity. Physician extenders are trained to handle emergency situations and provide immediate care where needed. Perhaps the greatest source of neglect in our area is in nursing home care for the elderly. Here, too, physicians' assistants would be available within our organization to provide regular care for those patients, most of whom are Medicare eligible recipients and all of whom require continuous treatment for their illnesses. The South Plains Health Provider Organization cannot accomplish all within our plans unless the future policy includes provisions for repayment and Medicare support for physician extenders.

It is difficult to know the full impact of the present policy of non-reimbursement on the private practicing physicians in our area. It is our opinion, that many physicians are reluctant to employ mid-level practitioners for that very reason. This opinion has been corroborated by several surveys made of physicians in Texas. They are aware that physicians' assistants are not eligible for reimbursement by Medicare and consequently will not hire physicians' assistants to expand their services to the people. We are of the opinion that if the present policy were changed, the private physician would have greater

opportunity to provide medical care to nursing homes and rural areas.

SUMMARY

The days of the "country doctor" are all but gone. In recent years medical care has been concentrated in urban areas and neglected in rural areas. Physicians are reluctant to open their practices in small communities. We, in Texas panhandle, are experiencing this trend and our patients who desperately need medical care, are feeling the neglect. Physician extenders represent the most immediate solution to the problem of delivering health care to the rural areas. Their training, skills, judgement and patient acceptance have been

tested and proven invaluable in expanding existing facilities to such as rural clinics and projects. The success of one such facility, South Plains Health Provider Organization, depends on the utilization of physician extenders and that successful utilization depends largely on the reimbursement of their services by medicare. We urge you to support the current legislation under consideration and change existing policies in Title XVIII of the Social Security Act.

I close with a quotation by George Herbert Tinley Kimble: "It is bad enough that a man should be ignorant, for this cuts him off from the commerce of other men's minds. It is perhaps even worse that a man should be poor, for this condemns him to a life of stint and scheming, in which there is no time for dreams and no respite from wariness. But what surely is worse is that a man is unwell, for this prevents his doing anything about his poverty, or his ignorance."

Thank you for the opportunity to present my testimony on behalf of the

rural population of Texas and all rural Americans.

STATEMENT OF SALLY SUNDBERG, MADRID, IOWA

This report is submitted in answer to your request for my views on the health services provided by a physician's assistant in the Madrid Community and the surrounding community, the role of Medicare in the provisions of those services, and the potential effect of legislation along the lines of S. 708.

Upon receiving this request I gathered information from residents of Madrid and the surrounding areas to determine the negative or positive feelings plus

expressed concerns regarding the services of a physician's assistant.

HISTORY

To fully understand the relevance of the need I include here a brief history

of the medical scene along with minimal community data.

Until six years ago Madrid had been served by a physician who not only provided satisfactory health care but had a financially successful practice. When he decided to leave this area, the Madrid Community Club along with the retiring M.D. started an intensive search for a replacement physician. The replacement physician vanished from the community early one morning leaving a 145 bed retirement-nursing home and a much larger medical practice without services. Through the concerned interest of a semi-retired physician in our county seat town of Boone, Iowa 15 miles away medical services were resumed by his Clinic, thus solving a health care crisis for the community. At that time the Boone Clinic had four practicing M.D.s and subsequently hired a physician's assistant extending services via a satellite Family Practice Clinic to the Madrid area and to the Iowa Lutheran Home for the Aging in Madrid. Internal attrition soon cut the medical staff in the Boone Clinic to two physicians who were themselves searching for replacement M.D.s. Unfortunately the dearth of physicians for the smaller clinics, even with good hospital facilities does not provide quick solutions, and the physicians find themselves today overloaded and in need of additional partners. This situation dictates that no new patients can be served at present. It was also reported to me that all Boone doctors have a full load and take new patients only for emergency treatment.

Since it is virtually impossible to provide M.D.s for all the needs it is imperative that other solutions to the doctor shortage must be examined. In S. 708 it appears a significant effort is being made to broaden health service to rural areas. It seems a visible and defensible solution to staff saţellite clinics with physician extender services, i.e., physician's assistants and/or nurse practitioners, thereby making available health care services to entire populations.

VIEWS ON HEALTH CARE PROVIDED BY OUR PHYSICIAN'S ASSISTANT

From the Madrid Community School it has been brought to my attention that children who are receiving welfare services under Aid to Dependent Children cannot now be seen for reimbursable services by the physician's assistant.



This situation dictates that the parent must be reached in the event of an emergency or that the child must be transported by ambulance to a physician, in our case 15 miles to the nearest hospital. This places the burden of medical decisions upon untrained school personnel and recently kept a child with a suspected concussion from receiving medical attention for several hours.

Our physician's assistant provides an entry into the health care system, making the necessary arrangements with hospitals, specialists, and/or family doctors depending upon the patient's needs. Examples: A recent measles epidemic aroused the concern of many area families. One 13 year old boy's mother called a nearby community pediatrician who under the strain of too much work, listened to symptoms of a 105° fever with a usual accompanying rash, and directed the mother to keep the boy in bed and to stop worrying. However, still concerned she later called the local physician's assistant who made a house call and immediately placed the youngster in the hospital with liver complications along with the high fever.

A six year old child experienced a virus infection, certainly not an uncommon event, but did not make adequate progress. The mother called the local Clinic and was told to bring him in right away and was subsequently rushed to a Des Moines hospital with Reyes Syndrome. Another accurate on the spot disagnosis of a severe medical problem had been made via the services

of the local Clinic.

Our New York Life Insurance representative indicated he had to have special permission to use the physician's assistant's physical examination for insurability of applicants but historically it has been their experience that the physician's assistants give more scrutenous physicals to determine the insurability than some examining physicians.

During a severe snowstorm last winter the physician's assistant helped move elderly and ill people from homes without heat and electricity. This operation was expedited by his knowledge of who and where these people were as well as having gained the trust of people to allow themselves to be temporarily

rehoused.

By alerting and instructing his patients he promotes preventive medicine and good health in the minds of many who would never give a thought to the prevention of illness.

Presently our physician's assistant is working on providing a Telemetry system to be used in conjunction with the local Rescue Squad and linked directly to the Cardiac Care Unit in the Boone Hospital. It is felt several lives could be saved each year by having such an emergency system available.

It is generally felt in our community that our physician's assistant is better trained to serve the general health problems today than the physicians of a generation ago. In discussions of the general use of physician's assistants, it was expressed to me, and I too, held some concerns for the level of professional skills that physician's assistants across the country might have. It became a question as to whether I really wanted to support legislation allowing physicians extenders to serve throughout the country. My fears were quieted as I learned that the sponsoring physicians assume total liability for the extender's medical actions, therefore, the sponsoring physician in all probability will have screened the skills of the extender personnel thoroughly and would be less apt to retain him/her than if he were a peer licensed physician with less than proficient skills. It has also been called to my attention that physicians who employ an assistant are less apt to have malpractice suits brought against them. The sponsoring physician of our physician's assistant pointed out (Note: He was originally opposed to the idea of using a physician's assistant) that in most cases the M.D.s do a better job in writing medical orders because the physician's assistant will be reading them and raising questions if something sounds unclear and the physician's assistant certainly does a careful job in writing up medical reports because he knows the physician will be scrutenizing them. In reality this operation provides an additional safety factor for patients.

As you all so well know, public transportation does not exist today as it did a generation ago, least of all in the rural sections of our country, yet medical knowledge has multiplied many times within the past generation. It appears to me that today we have greater medical knowledge with a large problem of how to get the expertise to the people. You, who are interested

in agriculture, will remember the "farm to market" roads that were so necessary in order to get the crop to the city and thus to the people. Today's problem can be likened to the same situation in reverse. We need to provide an avenue for medical services from the city (the medical research centers) to the country.

ROLE OF MEDICARE IN PROVIDING PHYSICIAN'S ASSISTANT SERVICES

The federal government through the Farm Home Administration has financed in Madrid a 22 unit senior housing apartment complex for people over 60 years of age with limited incomes. We all know this age group requires the greatest amount of medical services, which are also supported by government social services benefits. Without physician extender services the chairman of the Board of the senior housing indicated it would be difficult if not impossible to keep the occupancy to a level of financial solvency.

As a member of the Board of the Iowa Lutheran Home for the Aging I learned from first hand experience that the home would not be able to remain open without the services of the physician's assistant. 50% of the residents are on Medicaid and 100% qualify for Medicare. The largest age group is between 76 and 90 years with 23 residents between 91 and 100 and one over 100 years of age. If our Physician's Assistant could not be reimbursed for his services to these people, the doors to the Home would soon be closed.

Ripple effects result from changes in operations of this magnitude and the "Mea's on Wheels' program would also suffer. Today the Home not only serves its residents but provides meals for the "Meals on Wheels" for many of the

elderly residing in their own homes in the area.

Within the Home a weekly clinic is run to care for routine health problems with referrals to other appropriate medical services as deemed necessary by the physician's assistant. Each resident has the option of seeing the attending medical personnel or going out for health services of their choice, but by providing the in-house clinic it is not necessary for many to expend their waning or limited strength to obtain the needed medical attention.

It was brought to my attention by the Head Nurse in one of the Boone retirement homes that in addition to serving the Madrid community, our physician's assistant assists in weekly clinics held in the respective Boone homes, thus giving the aging residents medical care that would otherwise not be made

available to them.

POTENTIAL EFFECTS OF LEGISLATION ALONG THE LINES OF S. 708

As you can see by the preceeding discussion, the role of Medicare and Medicaid is a big one. The effect of present legislation with limited services to welfare recipients will not limit, but will in effect be a lethal blow to health care for many on welfare and also to the nearby populations who will also benefit by the propinquity of physician extender services. If a physician's assistant cannot be reimbursed for medical services to the elderly, this would impose a drastic limitation and in effect cut a medical practice to bits making it economically and time-wise inefficient. The sponsoring physicians in the Madrid local will not provide health care to this satellite community. They themselves do not have the time to travel to their patients because they already have horrendous health care responsibilities at their doors. It seems reasonable to believe that Madrid is not unique with this problem, rather it is a usual situation that cries for attention. Without the physician's extender services many citizens of our country who by rights of legislation and intent of the Social Security Act would be denied medical services.

According to Newsweek Magazine 2-28-77 Medicare and Medicaid have substantially eased the financial burdens of health care for the elderly, ensuring that they can withstand even serious illness without losing everything. Similarly, Congressional action to link social-security payments to the cost of living has gone far to ease money worries for the majority of old people who rely on the system as their main source of income. We now need Congressional action to assist in providing the avenue to medical services. It appears that today's legislation is incongruous with the intent of our welfare pro-

grams, be they serving the young or the elderly.

Another incongruity in our legislation appears when we realize that training programs for physicians assistants are supported with federal funds yet due to federal legislation the skills of the physician's extenders are limited.

I feel as does a large segment of our local population, that the proposed change in legislation S. 708 is a step in the direction of providing better service to the needs of a changing population. Philip Hauser, director of the Population Research Center at the University of Chicago says, "We are faced with the prospect of very drastic social, economic, and political change over the next quarter century." It seems this proposed legislation is looking ahead and could be appropriate to the needs of citizens for years to come.

IN SUMMARY

Madrid does not have an M.D. and probably will not have one for some time. Madrid is pleased to have the services of a physician's assistant.

The problem is, the federal regulations say the physician's assistant cannot be paid with Medicare funds for serving the elderly unless a doctor is present in the same room (a redundancy of services).

It seems one branch of the government is supporting the education of physician's assistants while another branch is limiting the services of the trained

physician's extenders, which are one and the same in many instances.

An appropriate change in legislation could solve the problem thereby insuring and expanding medical services to rural areas without cutting the quality of care.

[From the Madrid Register News, Madrid, Iowa, Thursday, March 24, 1977]

PUSTKA EXPLAINED "TELEMETRY" AND IT'S COST TO MADRID RURAL FIRE ASSOCIATION

Emergency Medical treatment and possible systems for treatment was presented and discussed by Rick Pustka, P.A. to the Madrid Rural Fire Association at their meeting held Friday afternoon at the community room.

Pustka spoke to the group on "telemetry", a compact suitcase carrying in it the latest in lifesaving devices. Only four cities in the United States, Los Angeles, New York, Cleveland and Seattle are using this system at the present

time, and it has been very successful in each.

Telemetry is the latest in comprehensive emergency care equipment and was utilized through the space exploration project at the National Aeronautical Space Agency (NASA) at Cape Canaveral in Florida. The tiny suitcase contains battery-powered equipment that will allow the literal "hook-up" of the patient to the coronary unit at Boone County Hospital. "It will give the coronary care nurse and doctor a complete status condition of the person: heartbeat, metabolism, pulse, all vital signs, and from this information, instructions for treatment and administration of drugs can be radioed to the members of the rescue unit," said Pustka. "All the information will be there for the decisions to be made in regards to treatment. It will be almost like having the heart attack in the coronary unit itself."

"At the present time without this equipment, a person suffering a heart attack, shock, burns, in a coma, needing amputation, diabetes, or any other serious condition, their chances of surviving is less than one-half of one percent," Pustka said. "Or in other words, 1 in 200 people suffering one of these ailments survive. In Los Angeles County, the successful resuscitative rate with telemetry is up to 20-30 percent. With the new machinery, it is possible to

afford people anywhere. Definitive care can be given."

"Right now, the only person in town who can administer drugs is myself and if I'm out of town there is no one in close proximity. That's why this system is so important to the rural communities because the people on the

local rescue unit can be trained to do this."

Pustka continued by saying there is not a better emergency medical system in any town in the state of Iowa than right here in Madrid. "For comprehensive care, the first 4-10 minutes after the accident or mishap are the most important if a life is to be saved," Madrid's physician assistant added. "We are talking of administering sophisticated lifesaving drugs, intravenous feeding, defibrillation, or the relaxing of muscle fibers of the heart, by shock treat-

ments to this area."

The system, however, is not without its drawbacks. Cost is probably the number one factor at this time. "To purchase this unit, it would take \$25,000," Rick stated. "Boone County Hospital is willing and has agreed to accept the legal and moral responsibilities involved. But the important point is that nonmedical people will be able to administer lifesaving drugs during the critical period."

Rick suggested to the Rural Fire Association, who openly approved and gave their backing to this unit, that a local organization coordinate a fund raising project to get things going. "No Federal funds are available for emergency medical equipment," he said. "I have written to Kellogg's and Johnsons and Johnsons, who have grants available for this type of equipment, explaining our situation."

A question was raised on liability for the people administering the drugs. "I believe and those lawyers I have contacted agreed, that the 'Good Samaritan Act, which governs the rescue and fire departments now will be applicable in this situation. Where no fee is charged there is no liability."

The Hospital has also agreed to put those interested persons through a series of drug and IV classes at no cost. After successful completion of these classes, they would be certified by the Hospital. Pustka also said that yearly recertifications would also be in order, but first, the program has to get started.

NEW PICKUP PURCHASED

Prior to Pustka's presentation, Fire Chief Buck Muehlenthaler told the group of the purchase of a 1964 Dodge, 4-wheel drive 6 passenger pickup. Purchased from the Forestry division of the Iowa Conservation Commission, the truck arrived last Thursday and will be used to transport additional firemen to meetings and fires. The vehicle was purchased for \$100.

Muehlenthaler also said that a trailer and possibly a generator from other sources can be obtained for the local department. He also gave some information on the Boone County Communications Center, currently in the planning

stage.

STATEMENT OF RICHARD A. PUSTKA, PA-C, FAMILY PRACTICE CLINIC, MADRID, IOWA

Following a brief personal introduction and summary of the medical delivery system of which I am a part, I would like to offer a brief overview of what is happening in the state of Iowa and the potential effect of legislation along

the line of S. 708, which will include definitive suggestions.

I am a Primary Care Physician's Assistant, graduate of the Physician's Associate Program, United States Public Health Hospital, Staten Island, New York, I successfully wrote the first certifying examination administered in December, 1973, by the National Board of Medical Examiners and am currently certified by the National Commission of Certification of Physician's Assistants. As a member of the American Academy of Physician's Assistants, I am required to periodically recertify through the continued demonstration of competency including documentation of continuing and meaningful medical education and the successful completion of a periodic national re-examination. I am currently serving as a committeeman on the AAPA's national membership committee. As the founder and first elected President of the Iowa Physician's Assistant Society, I remain actively interested in problems concerning Physician's Assistants in Iowa.

I have been asked to add that I served as a corpsman in the United States Navy for 4 years, serving 1 year in Vietnam, receiving decorations including the Purple Heart, the Silver Star and the Vietnamese Cross of Gallantry.

Immediately following my graduation in August of 1973, I have worked as a Physician's Assistant for a group of Family Practitioners in Boone, Iowa. After an extensive 3 month period of direct supervision by these physicians, (which included, by the way, a learning process on their part, as to just what a Physician's Assistant is, what he does, and specifically the extent of my training, experience and competency) and at the request of a group of citizens

in Madrid, a satellite clinic was initiated. The Family Practice Clinic is staffed by myself, 1 nurse and a receptionist under the supervision of Drs. Rouse and Anderson in Boone, 14 miles away (supervision includes by-weekly visits, continuing daily chart supervision and a communication system including radios, telephone, and the County Hospital Ambulance Service). Madrid is a rural community located in central Iowa with a population of approximately 2,200. In Madrid there is a 150 bed nursing home and a 22 unit senior housing project. Our satellite office is the sole provider of medical care for this community. I would, at this time, refer you to Mrs. Sally Sundberg's testimony which gives an indepth look into the history of medical care availability in our community. I might note that I reside with my wife and 2 children in Madrid.

As a direct extension of Drs. Rouse and Anderson, I render care to over 2,000 active patients, representing a typical cross section of all ages, economic productivity, coupled with the overwhelming desirability of locally available medical care. This care, although not all inclusive, includes health maintenance, preventative medicine, with emphasis on family practice including acute care under any and all circumstances. This satellite office is currently part of a social security's administration research study allowing reimbursement to the physician for care rendered by myself to the elderly patients eligible for Medicare assistance. Only because of this study is it possible for; 1) this satellite office to continue operation as the sole provider of medical care in Madrid; 2) for the ambulatory elderly to receive medical care without prohibitive out-of-pocket costs; 3) for our local 150 bed nursing home to keep its doors open with the availability of immediate emergency medical care through my utilization by my supervising physicians which includes a weekly clinic visit.

An explanation of the delivery of health care specifically to the residents of the local nursing homes prior to the initiation of the satellite office here in Madrid may be helpful in gaining insight into cost of care. With no medical telephone, at times difficult due to tremendous overload and a busy practice. service available to the community prior to 1973, and given the following limitations to the following example, a nurse in her usual competent and professional manner would recognize that an acute problem, in this case pneumonia, was apparent, would contact a physician in Boone (14 miles away) by Once this feat was accomplished and the physician convinced that the patient was indeed in need of immediate care, an ambulance would be dispatched from the local county hospital. The patient would be seen in the outpatient department, rendered care, and in this example, without a hospital stay, would be transported again by ambulance back to the nursing home. The cost for this care would exceed \$100. In comparison within the past month, I was notified of a similar problem by the nurse in the nursing home. Within a very short time after examination of the patient and phone consultation with my supervising physician, definitive diagnosis and treatment was initiated. The actual charge was \$30 and in reality, actual cost was \$20 after Medical assignment was accepted.

As a Physician's Assistant, I do not consider myself a replacement physician. I have long and often proposed that the complete answer to the availability of medical care in rural areas is more physicians. I would, although, like to, at this time, direct your attention to addendum 1 to this testimony entitled, "Medex and Their Physician Preceptors, Quality of Care", from a department of family and community medicine, University of Utah, College of Medicine, Salt Lake City, published in the journal of the American Medical Association, Nov. 29, 1976, Vol. 236, No. 22. In summary of which when outcomes of care were determined in 13 practices with a Medex and a Preceptor, the patients seen by the Medex (Physician's Extender) tended to fair about as well as those seen by a physician (71% vs. 74%, respectively) in regaining their usual functional status. The addition of a Medex (Physician's Extender) to a rural practice may thus produce both direct and indirect benefits.

Concerning a brief overview of what is happening in Iowa, I call your attention to the hearings before the subcommittee on rural development of the committee on agriculture and forestry of the United States Senate, 94th Congress, 2nd Session, presided by Senator Clark on October 12, 1976 in Grimes, Iowa entitled, "Rural Health Services in Iowa". Senator Clark's astute and

direct ability in recognizing problem trends in Iowa was correct. Reading directly from HEW's statistical charts concerning the percent increases in physicians by geographic division in state in the United States between 1968 and 1973.

Mr. Clark: "These are the latest figures we could get. In other words, how much in Iowa, as compared to the rest of the nation—what kind of percent increase in physicians have we had? Unfortunately, we are 49th among the 50 states. This is increased number of physicians in the state. We have had, in that 5 year period, a 6.3% increase The national average is 16.7% so that we are well below half of the national average in terms of increasing physi-

cians into the state.

There is one state lower, and interesting enough, it is South Dakota, and it is much lower, 1.4%. We are second lowest, 6.3%, and then they are all the way up to New Hampshire, which must be the climate, 26%, so that I noticed in passing that Mr. Pustka said that he felt the final answer was not simply Physician's Assistants, but doctors themselves and if these figures are still accurate over the past 2½ years, these trends, it means that we have a real problem in terms of physicians as well".

Yet extensions of the primary care physician in rural Iowa, specifically through the utilization of Physician's Assistants, has proven to be an immediate and direct workable facet of the problem of health care availability

in rural Iowa.

Quoting Denis R. Oliver, Ph.D., director Physician's Assistant Program, University of Iowa: "Let me highlight certain points. To date, we have graduated 45 Physician's Assistants with B.S. degrees conferred by the College of Medicine. Thirty-two (71%) are currently employed in Iowa. Each year we accept between 20 and 25 students to enter the 2-year program. This program has scored among the top 5 programs in the country (out of 52 programs) on the national certification examination for Primary Care Physi-

cian's Assistants for the last 2 years.

We are proud of our program and the caliber of our graduates. We feel they will have increasing impact on rural health delivery systems, but only if appropriate legislation exists which allows for their optimum utilization. The position of the social security administration on third party reimbursement for Physician's Assistants services to Medicare patients is ridiculous. On the one hand, the government budgets enormous sums of money for the initiation and continuation of Physician's Assistants training programs, and on the other, severely restricts their utilization. This is of particular concern in Iowa which has a large elderly population. I think it criminal that these people are abandoned at a time when they should enjoy the fruits of heir labor".

Both Senator Clark and Dr. Oliver's comments adequately summarize specific issues concerning availability of health care in Iowa. Again, not a complete answer, the Physician's Assistant's utilization under adequate supervision by practicing physicians is a partial immediate, even longterm answer to the frequently forecasted worse physician shortage for the future in rural areas. Specifically, in Iowa, one-third of the counties lost Primary Care Physicians in the years from 1974 to 1976 alone. At the same time, only about 4% of the recent medical graduates have chosen to practice in rural areas. These stark facts coupled with enumerable practices (for example, generally lower fees given to physicians in rural areas compared to urban areas by both private and public health insurance programs) and the obviously contradictory reimbursement system of Medicare disallowing the utilization of Physician Extenders (who have been proven, can substitute under adequate supervision for the declining number of physicians in rural areas) is presently compounding what is considered by many to be an acute medical crisis. The populus of Iowa has been historically fortunate in that the availability of medical care through a high caliber and standard of Iowa physicians, private and county hospitals, and the University of Iowa Hospital system, has been available. The problem boils down to one of entry into the system. The Physician's Assistant has shown to be an available, competent entry into an excellent medical system where otherwise an entry was not readily available.

I conclude that the serious responsibility shared by the subcommittee on rural development in its recommendations and support of legislation along the

lines of S. 708 will be felt immediately and in the future by many if not all of our friends and neighbors. I respectfully submit the following suggestions:

1. S. 708 is glaringly lacking and limited in its reimbursement to rural medical clinics in medically underserved areas at cost. Reimbursement to physicians practices for services rendered by the Physician's Assistants in any and all areas should and must be priority. The availability of primary medical care to the people in the core cities and other areas is just as real, just as acute, as that of the rural areas. Reimbursement as I've just outlined may be compromised and/or facilitated by a reimbursement program discounted from that of the physicians usual and customary (80%?) when the care is indeed rendered through the Physician's Assistant.

2. The concept of medical care rendered by a Physician's Assistant was born in the realization that all care rendered by the Physician's Assistant would be under the supervision of a physician who ultimately would hold both moral and legal responsibilities completely. This concept is the underlying premise on which the extender concept remains workable. The Physician's Assistant is only as good as the supervising physician. In my interpretation of S. 708, I have to agree in part with Dr Beddingfield (Chairman of the AMA Council on Legislation) in that by this bill's definition, clinics cannot be physician directed or under direct personal physician supervision covering only certain types of state health clinics. This, in my estimation, may leave a door open to widespread, if not dangerous abuse of our Medicare system. The Physician's Assistant must remain a direct extension of his supervising physician and should at all times be directly answerable to and employed by a physician and very close supervision of the extender by the physician be encouraged. The original concept as outlined by our congress must be continued and fostered in that ultimate responsibility of the Physician's Assistant must rest with his supervising physician.

3. The fee schedules which discriminate against rural practice must be erased. Routinely, insurers, including titles XVIII and XIX pay higher fees to urban doctors than to rural doctors for the same work. Urban doctors have offered convincing arguments for their higher fees, but the difficulty in getting doctors into rural practice is an adequate answer to all such arguments.

4. A priority commitment to seek a successful program to increase physicians availability in rural areas should be continually explored. Positive programs such as tax credits for "area practice", encouragement of utilization of Physician Extenders through adequate reimbursement programs, and family practice residency programs by state universities with preceptorship training in rural communities have all been positive directions. An important negative direction has been the utilization of "short time doctors". Schemes to get doctors to rural communities for short periods of time, including 2–5 years, have a tendency to attract inferior physicians and is insulting to the rural population. Rural practice is a specialty and a career.

Î accepted this invitation to testify as an honor and would, at this time, like to conclude with a thank you forwarded by many residents of Madrid for your time, concern, and apparent wish to insure, through effective and farreaching legislation, availability of medical care; hopefully, irregardless of a

person's age, ability, disability, or geographic locality.

STATEMENT OF BETSY DAVIS, EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION, INC., BURLINGTON, VT., AND CHAMPLAIN ISLANDS HEALTH CENTER, GRAND ISLE, VT.

I am Betsy Davis, Executive Director of the Visiting Nurse Association, Inc., located in Burlington, Vermont, serving Chittenden and Grand Isle counties. I am also project director of the Champlain Islands Health Center, a rural health center operated by the VNA and the Grand Isle County Health Council. I am pleased to have the opportunity to appear before you today to discuss \$.708 and the implications of that bill as it affects the financial viability of the Champlain Islands Health Center.

I wish to present you with the background in creation of the Health Center, a brief description of the system of care, a description of a pilot reimburse-

ment project with Blue Cross/Blue Shield and the potential effect of 8.708 if implemented.

BACKGROUND

The Champlain Islands Health Center is located in Grand Isle County in Northwestern Vermont. The county is composed of a peninsula that leads to Quebec Province in Canada and is a series of islands in Lake Champlain which is connected by a sand bar and bridges. It is approximately 40 miles in length and three miles wide at its widest. The population is approximately 3,750 but swells to 12,000 during the summer tourist season. The mortality rates show that there are higher rates in comparison with the rest of the State of cardiovascular and respiratory disease, cirrhosis of the liver, and accidents. Women die sooner than men with the mean age of the former at 66 and the latter at 70. The population characteristics and economics of the area probably typify many rural areas, such as: 58% of the population of Grand Isle County earns less than 200% of the poverty level; last winter's unemployment rate was over 17% of the work force, 28% of the population presently utilizing the Health Center have no form of health insurance of any kind, and only 15% are Medicaid eligible. Many are only marginally employed.

Historically, solo physicians have come and gone in the county with none being able to support a comprehensive practice over an extended period of time. The last physician in primary practice offered services two afternoons a week in the northernmost town of Alburg (also the largest town) and practiced surgery at a hospital in another county the remainder of his time. He has now discontinued his services in Alburg. There is an osteopath in the southern part of the county offering episodic illness services to a limited population. VNA initial experience in Grand Isle County was with a mobile unit pediatric screening service in 1972. The data base collected there showed that 32% of the children presenting at the mobile unit did not have a source of preventive care; 45% of the children presenting had irregular patterns of utilization of preventive services. Utilization of the mobile unit services by the preschool population was 50%–90% in the various towns in the first year of operation. Patterns of health care by adults were fragmented and inadequate with many naming 3 or 4 physicians that they would turn to depending on who was available. Almost no one had a record of his or her problems, medications, or plans.

DESCRIPTION OF THE SYSTEM OF CARE PROVIDED BY THE HEALTH CENTER

Our major goal in establishing the Health Center three years ago was to provide a coordinated integrated system of health care that is available, accessible, and accountable to the people of Grand Isle County. The important features of the Health Center are: 1. consumer involvement and governing responsibilities; 2. utilization of nurse practitioners as primary caregivers with back-up physician availability through telephone consultation and periodic on-site visits; 3. the linkages to the rest of the health care system; 4. that it is cost effective; 5. that services focus on prevention and health education; 6. that it is accountable.

I would like to address each point briefly.

It was through the initiative, support, and many ongoing volunteer hours of the County Health Council that the Health Center was established in 1974. It was they who asked if we could keep the nurse practitioner from the mobile unit on a daily basis and expand to adult services. This group now has responsibilities for program and services planning, budget and contract approval, evaluation and other policy determinations. In addition, a consumer advisory committee has been created which makes recommendations to the Health Council on needs for services and provides a feedback mechanism for patient complaints. The VNA and other involved agencies support this local responsibility believing that health care providers must be accountable to the people we are trying to serve. This increased involvement will also lead to increased responsibility, greater self direction and hopefully more demand for a system of health care to which people are entitled. It is for this reason that we believe that a certain, defined level of health care should be community based and located where people live.

We believe that transporting people 30-60 miles to health services they have

no responsibility for is self defeating.

Nurse practitioners and a paramedic staff the Health Center daily. They perform preventive maintenance exams for infants, children and adults as well as treatment of acute or chronic illness by protocol or telephone consultation. Each patient identifies a physician who may be located either in Franklin County or Chittenden County with whom the nurse practitioner communicates and to whom she sends records. Consulting and medical/legal back up are provided by contract physicians who are available by telephone and who are on site once a week to perform record audit, establish protocols and see patients with the nurse practitioner on a consulting basis. There is an evening and night answering service with a tie-in to physicians at the Villemaire Health Center located in Milton, and Given Health Center, both affiliates of University Health Center. VNA home care services are operated out of the Health Center and coordinated with ambulatory services.

The nurse practitioner concept has been well accepted. Almost 800 people made 2,240 visits to the Health Center in its first year of operation when it was open four or five half days per week. 98% of all acute pediatric problems and 93% of all acute adult problems were cared for on site. The remainder were triaged outside of the county. The second year showed a

34% growth.

The nurse practitioner serves as an extension of the health care system providing an entry point to total care. She is part of a larger support system. It is our task to 1) define those primary care services that can be provided on site in Grand Isle County considering the population base, the population problems, and economics of the area, and 2) provide a consistent and reliable service on site and guide the patient through the rest of the health care

system.

Again, critical to that system is the involvement of the patient as the coordinator of his or her own care. This means full knowledge, understanding and participation in health care. Patient education and the problem oriented health care record in the patient's possession are central to this concept and practiced at the Health Center. We believe that nurse practitioners, by their professional education and focus on prevention, are best prepared to provide these important components of education and guidance necessary in primary care. This should mean more appropriate utilization of health services, less duplication and greater efforts toward self help. This should also mean increased levels of expectations on the health system and greater accountability.

The average cost per visit in the Health Center the first year was \$11.55 after deducting developmental expense and \$12.50 in the second year. These figures included all screening and laboratory tests also done at the Center. For the people utilizing the Center, there were additional savings when travel

expense, loss from work, and child care concerns are considered.

During the second year we had great concerns about our ability to continue the Health Center for financial reasons. The first year had been financed through a Manpower HEW grant, Kellog funds, and Health Department support as well as patient fees. The second year showed a continuation and carry over of some of those funds, and Regional Medical Program funds were received; but we operated on a shoestring basis. It was painfully clear that third party reimbursement for nurse practitioner services when an M.D. was not on site was a critical issue in the continuation of the Center. If the problem of third party reimbursement could not be solved, then the nurse practitioner as an extension of the health care system in rural areas was not viable. Yet, we felt we had been able to create a quality service that was acceptable, accessible, accountable and cost effective. Fortunately, we were awarded a Rural Health Initiative grant from Region I HEW July 1, 1976, giving us more time and ability to further develop the system and to work toward improved reimbursement.

We realize that grants cannot be a long term solution and that the Health

Center must fit in with the prevailing methods of reimbursement.

BLUE CROSS/BLUE SHIELD REIMBURSEMENT PROJECT

A major innovative step has been taken by Vermont/New Hampshire Blue Cross/Blue Shield in addressing the reimbursement of services provided by

nurse practitioners. Their interest in this venture came as a result of participation in the Rural Health Hearings held in Vermont and sponsored by Senator Leahy and Senator Clark and this subcommittee where reimbursement issues were presented. Blue Shield officials visited the Health Center, met with consumers and beneficiaries, reviewed the system of services and entered into a contract with the VNA September 1, 1976. The contract itself offers a model for reimbursement. The VNA bills monthly on a ledger sheet all the charges for that period incurred by Blue Shield beneficiaries. The VNA is reimbursed directly. At the end of six months, an audit will be performed and a retroactive settlement considered on the basis of mutual costs of services based on number of visits by Blue Shield beneficiaries. It is an amazingly simple process, and we are very encouraged by Blue Shield's leadership. I believe the important components of this contract are: 1. that it reimburses a system and not the individual practitioner for services provided; 2. that it requires a system of care that is accountable, and has mechanisms for ongoing audit of practice of all the providers of care; 3. that it reimburses on the basis of actual costs following audit.

In the first five months, 14.69% of the visits to the Health Center were by Blue Shield beneficiaries. This means that as long as we can demonstrate prudent fiscal management and cost effectiveness, we can count on 14% of

our costs being met by this contract.

IMPLICATIONS OF S. 708

10.9% of the population (409 individuals) in Grand Isle County is over 65. Approximately 180 people or 44% of that population have been seen at the Health Center over the past two years. If there was reimbursement for the services provided for that population, we believe that this would represent approximately 20% of all services provided. This would be one more very important step to improving the financial viability of the Health Center.

Passage of S. 708 would remove a significant barrier in supporting the concept of rural health centers and the system I have attempted to describe. We believe that nurse practitioners and physician assistants as part of a team provide an appropriate entry point to a total system of care and assist in creating the necessary linkages to that system. We believe that this concept could be critical in helping to create order out of the chaos of the present non-system. And finally, we are convinced that improved accessibility combined with education and consumer responsibility leads to earlier intervention in illness, improved preventive practices and ultimately reduced costs of total care.

Thank you for this opportunity to express our support of S. 708.

STATEMENT OF DAVID A. HANTMAN, M.D., AND LINDA LABROKE, R.N., DANVILLE HEALTH CENTER, DANVILLE, VT.

The Danville Health Center is a rural health clinic recently established to offer geographically accessible comprehensive health care to an isolated area of approximately 3,000 people in northeastern Vermont.

CHARACTER OF THE AREA

This is a rural area with an economic base of farming, trade, and some light industry. The unemployment rate is high, and the per-capita and perfamily income are far below state and national averages. The number of individuals and families qualifying for welfare assistance under various programs exceeds the state average.

Until the Danville Health Center was established, no medical care was available in Danville. The nearest physicians are in St. Johnsbury, 10 miles

away. St. Johnsbury also contains the nearest hospital.

THE DANVILLE HEALTH CENTER

The Center is staffed by a Family Nurse Practitioner, Ms. Linda Labroke, and supporting personnel. Physician supervision is provided by two Internists

with a private practice in St. Johnsbury, Drs. David Hantman and Jerry Berke. The Center is open 40 hours a week, during which time patients are seen by appointment by the Nurse Practitioner. Physician visits to the Center are limited to ½ day per week for consultations on patients with complex medical problems. Physician supervision is provided by telephone consultation with the Nurse Practitioner, by referral of complicated or severely ill patients to the physicians' office or to the hospital under their supervision, and by routine physcian audit of all patient records. Most important, treatment protocols dealing with specific medical problems, written by the physicians, are used by the Nurse Practitioner in managing patients.

The Center was established with the close cooperation and continued support of the citizens of Danville and their elected representatives. A fourteen member board of directors representing the community directs the operation of

the Center, which is organized as a non-profit corporation.

The Center operates on a fee for service basis, with fees set at a lower level than prevailing physicians' fees in the area. We have received a two year grant from the Kellogg Foundation to cover some of the start-up costs. A pilot reimbursement program was begun at our suggestion by the Vermont-New Hampshire Blue Cross/Blue Shield to reimburse for Nurse Practitioner services.

The Center offers comprehensive health care, including treatment of acute and chronic medical problems, preventive medicine and health maintenance services such as complete initial and annual physical examinations, hypertension screening, routine Pap and breast examinations, dietary instruction, and family planning services. A wide variety of health education programs are planned.

THE ROLE OF MEDICARE

An estimated 25% of patient visits to the Center will potentially be covered

by Medicare.

We strongly believe that the inclusion of physician extender services under Medicare will benefit our patients in two ways: by increasing the accessibility of health care and by reducing health care costs.

1. INCREASED ACCESSIBILITY OF HEALTH CARE

Our Center has increased the geographical accessibility of health care services to the residents of the Danville area. In addition to making it easier to obtain routine and emergency care, we feel that we are able to provide care for many elderly individuals who up to now have received no care at all, or who have sought medical attention only in emergencies, because of their distance from other facilities. Without Medicare reimbursement, contact with these individuals would be lost.

More important, we must become self sufficient on a fee for service basis within two years. Medicare reimbursement for 25% of the patients seen at the Center would provide an estimated \$14,000 of the \$56,000 yearly operating budget of the Center. Without these funds, the Center would not be able to survive past the duration of our Kellogg Foundation grant.

2. REDUCTION OF HEALTH CARE COSTS

We feel that our Center, incorporating the classical concepts of physician extender use, can effect substantial savings to the patients and to the Medicare program itself. As outlined in Table 1, which compares costs in the Danville Health Center with costs in nearby physicians' offices and with those in the local hospital emergency room for treatment of two representative acute illnesses, savings of between 15% and 60% can be effected.

Furthermore, routine health maintenance and preventive medical services may reduce the need for expensive hospitalizations in our patient population.

We at the Danville Health Center feel that passage of S. 708 would be beneficial in helping us increase the availability of medical care to the elderly population of our area, and that it would help reduce the costs of medical care. We recommend passage of the Bill.

TABLE 1.—COMPARISON OF COSTS OF TREATING 2 REPRESENTATIVE ACUTE ILLNESSES IN THE DANVILLE HEALTH CENTER, LOCAL PHYSICIANS' OFFICES, AND IN THE LOCAL HOSPITAL EMERGENCY ROOM

Procedure	Total cost	Paid by medicare (80 percent)	Paid by patient or coinsurance
I. Acute Upper Respiratory Infection	With Streptococc	al Pharyngitis	
I. Danville Health Center:			
Office visit	\$8.00 3.00	\$6.40 2.40	\$1.60 .60
Throat culture 10-d supply of penicillin		2. 40	2.00
Total	13.00	8.80	4. 20
Physician's office: Office visit	10.00	8,00	2, 00
Throat culture	3, 00	2, 40	. 60
Penicillin			3. 25
Total	16. 25	10.40	5. 85
Hospital emergency room:	10.00	8, 00	2, 00
Emergency room chargeEmergency room physician's fee	10.00	8.00	2. 00
Throat culture	9.60	7.68	1. 92
Penicillin	3.25 _		3. 25
Total	32, 85	23. 68	9. 17
aving: expressed as absolute amount/percentage saving: Danville Health Center versus physician's office Danville Health Center versus hospital emergency	\$3.25/20	\$1.60/15	\$1.65/28
room	\$19.85/60	\$14.88/63	\$4.97/54
II. Minor Laceration Not	Requiring Suturin	g	
. Danville Health Center:	# 0.00	0.40	¢1 CO
Office visit Tetanus toxoid	\$8. 00 2. 00	\$6. 40 1. 60	\$1.60 .40
Total	10.00	8.00	2.00
Physician's office: Office visit	10.00	8, 00	2, 00
Office visit	10. 00 3. 00	2.40	.60
Tetanus toxoid			0.00
Total	13. 00	10.40	2.60
TotalHospital emergency room:			
TotalHospital emergency room:	15.00	12. 00	2.60 3.00 2.80
Total			3. 00 2. 80
Total	15. 00 14. 00	12. 00 11. 20	
Total	15.00 14.00 1.00	12.00 11.20 .80	3. 00 2. 80 . 20
Total	15.00 14.00 1.00	12.00 11.20 .80	3. 00 2. 80 . 20

STATEMENT OF JOHN W. RUNYAN, JR., M.D., PROFESSOR AND CHAIRMAN, DE-PARTMENT OF COMMUNITY MEDICINE, UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE, MEMPHIS, TENN.

Nearly half the population of the United States suffers from one or more chronic diseases. (1) This segment of the population is estimated to account for 80% of all health care services delivered. Those in the medicare age group account for the largest share of this chronically ill population. It is becoming increasing apparent that continuing care for the mounting population of chronic disease patients by physicians on a one-to-one basis is impossible and the attempt may be a misdirection of the physician's time and talent. The care of most chronic disease patients centers on patient education and counseling and empathy with adjustments of a simple therapeutic program from time to time. The training of the primary care physician extenders encompasses these important elements of care.

Our studies indicate that in the system of health care delivery in Memphis and Shelby County operated by the Health Department that the nurse in an extended role utilizing written protocols with physician and medical center back-up can provide services of high quality. (2-8) Currently there are 26 decentralized clinic locations in both urban and rural areas of the county where this care is provided for a population of about 225,000 out of the

The studies relating to quality of care and hospital utilization that have been underway for the past six years involve a subset of the chronic disease population of 10,000 of which 90% have hypertension, diabetes mellitus, and cardiac disease. The blood pressure levels in hypertensive patients are maintained within an acceptable range in 95 to 96% of patients with a follow-up rate of 75% over the past five year period. These results compare favorably with those under physician care in the City Hospital and with research studies being conducted on a national level by the National Heart, Lung and Blood Institute. There is a reduction after transfer to this decentralized network of 52% in hospital utilization for these hypertensive patients with a significant decrease in the occurrence of stroke and congestive heart failure which are known to be complications of inadequately controlled high blood pressure.

(See Appendix 2)

county's 750,000. (Appendix 1)

For patients with diabetes mellitus hospital utilization is decreased by 49 per cent. After four years over seventy percent of the initial diabetic population is being followed with average blood sugars levels maintained within satisfactory levels as outlined in the goals of therapy in our protocols which are published as the Primary Care Guide. (9) Hospital utilization for the preventable complications such as diabetic acidosis, (the extreme form of diabetes), severe infections as a result of uncontrolled diabetes and lower extremity amputations from poor blood supply and infection of the feet are significantly reduced. (See Appendix 3) In an entirely rural care system operated in Kentucky by nurses with physician back-up (i.e. Frontier Nursing Service) hospitalization rates for diabetic patients are also considerably less than the national average. The average number of days spent in a hospital nationally per year by diabetic patients is 5.4, while in the Memphis and Shelby County Program it is 1.68 days and for the rural Kentucky Frontier Nursing Service it is 1.6 days per year. In urban Los Angeles when ambulatory care was made more accessible to diabetic patients, including the use of physician extenders, there was a reduction of 5.6 to 1.74 days per year. (See Appendix 4)

Since in our program ambulatory and home care are emphasized, over-all health care costs are significantly reduced for each day that a patient can be kept out of the hospital can pay for many ambulatory and home care visits. Physician extenders trained in primary care are oriented towards ambulatory and home care which are the most suitable locations to administer to the chronically ill and elderly unless hospitalization becomes mandatory. The benefits to their health and well being that elderly people receive upon hospitalization is often questionable and certainly many do better in the familiar surroundings of their own home or in a clinic with devoted, friendly professionals and personnel. Since home care is such an important extension of health services, I would suggest that its availability be considered as a criteria to

qualify for medicare reimbursement for rural clinics.

Other medical services are offered adults as well as other age groups by the Memphis and Shelby County network of clinics including episodic care of common problems and self-limited illnesses (see Appendix 5). However, my research has not extended to these other services but of course they are essential for a rural clinic. Even though I have no personal data other reports and our own experience suggest that physician extenders can be very effective in providing these services.

It would be my opinion that Bill S. 708 has those essential ingredients that would promote high quality and safe care for the rural elderly, particularly if some type of home care services could be provided. I have entered the published papers that have arisen from our work in Memphis and Shelby County.

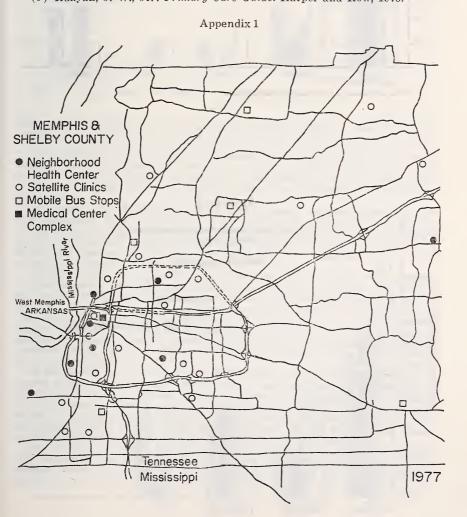
Thank you.

REFERENCES

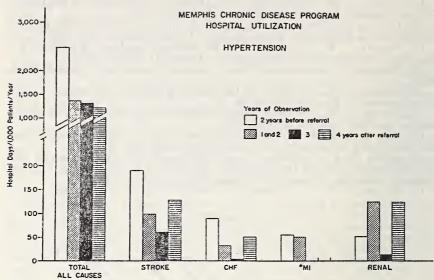
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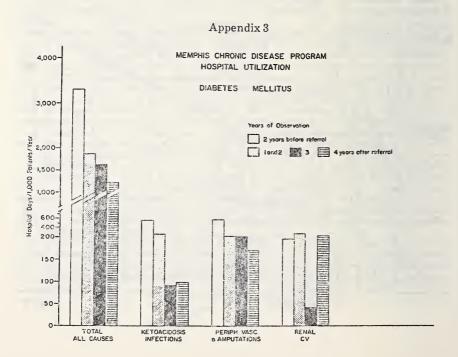
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Appendix 2



^{*} There were no hospital days for MI (Myocordial Inforction) in years 3 and 4.



[Appendix 4]

DIABETICS-AVERAGE DAYS SPENT IN A HOSPITAL YEARLY

	Before	After
National_ Los Angeles County Hospital Memphis Chr. Dis. Prog Frontier Nursing Service	5. 4 5. 6 3. 32	1. 74 1. 68 1. 6

[Appendix 5]

Major clinical services

Neighborhood Health Center:
Chronic disease
Primary care (adult)*
Ante-partum
Family planning
Well child

Sick child

Chronic disease Ante-partum Well child Family planning

Satellite Clinics:

Home:

Chronic disease Primary care (adult)* Home nursing Mobile Bus (Rural):

Chronic disease Well child Family planning

* Refers to triage, common problems, and self-limited illnesses.

STATEMENT OF STEPHEN C. CAULFIELD, ASSISTANT DIRECTOR, REGIONAL OPERATIONS, UNITED MINE WORKERS OF AMERICA, HEALTH AND RETIREMENT FUNDS

Mr. Chairman, the United Mine Workers of America Health and Retirement Funds are grateful for this opportunity to appear before this Subcommittee to present testimony on Medicare reimbursement for rural health clinic services, including those provided by nurse practitioners and physicians assistants.

The Health and Retirement Funds are successors to the original Welfare and Retirement Fund established by the Krug-Lewis Agreement in 1946. The Funds provide health and pension benefits to a population of over 800,000 coal miners, retired and disabled miners, and their dependents, living in all 50 states, but concentrated in the coal field areas of Appalachia, the Upper Mississippi Valley, and the rural West.

The Funds are multi-employer joint Trusts established under Section 302 of the Taft-Hartley Act. The agreements under which we operate are adopted as part of the collectively-bargained wage agreements between the United Mine Workers of America, the Bituminous Coal Operators Association, the Association of Bituminous Contractors, and individual coal operators and coal haulers. Eligibility for, and level of benefits, and rates of payment from the signatory companies are established for the term of the collective bargaining agreement by the Trusts' settlers. The Funds are administered by a three-member Board of Trustees.

As you know, coal mining is one of the most dangerous occupations in the United States, and it should therefore be no surprise that our population has a very high rate of medical problems which require professional care. The high incidence of disease and accidents, coupled with the traditionally poor access to medical care in the rural areas we serve, and compounded by other hardships of rural and mountain life, have made the 30 years of the Funds' medical program a unique chapter in American health care.

Our program is costly, but not excessive in terms of national figures. In 1976, the Funds paid out almost 225 million dollars for health care for our covered population, about 45 million dollars of that for beneficiaries on Medicare.

Unlike other third parties, the Health and Retirement Funds control neither the level of benefits nor the income to cover those benefits. Both benefits and income are negotiated through the collective bargaining process and established prospectively in each coal wage agreement.

The Funds are also not a direct provider of medical care; we own no hospitals or facilities and employ no health care providers. (Although, historically, the Funds did establish and operate the Miners Memorial Hospitals. These were sold in 1963 to the Appalachian Regional Hospitals, Incorporated).

Thus we are continuously faced with the challenge of how we can use purchasing power and administrative interventions to make quality care accessible and available to our primarily rural beneficiary population, while at the same

time controlling costs.

Our reimbursement mechanisms include both fee-for-service and cost based arrangements. We have used our purchasing power to encourage the development of group practices and non-profit community clinics, modes of delivery we tend to favor. Administratively, we have created a limited list of participating providers based on need, quality, administrative compliance and costs. We have also administratively imposed a prior approval requirement for certain procedures such as tonsillectomies and adenoidectomies and have been one of the first third parties to only reimburse for drugs prescribed from a limited formulary. We have also aggressively, but sadly, unsuccessfully, fought for construction of unnecessary hospital beds.

We have long fought for one level of benefits and care for all of our beneficiaries regardless of age or location. This philosophy has led us to a rather unique arrangement with the Social Security Administration for our Medicare enrolled beneficiaries, which now number more than 120,000. While the Funds pay the Medicare Part A deductibles and coinsurance, the unique aspect of our Medicare program is that we pay for all Part B services for these beneficiaries as a Group Practice Prepayment Plan dealing directly with the

Social Security Administration.

Under this G.P.P.P. arrangement, physicians and clinics make no distinction between our beneficiaries who are Medicare enrolled and those who are not. All services are billed directly to the Health and Retirement Funds according to a predetermined reimbursement plan based either on cost or fee-for-service. We, in turn, allocate our expenditures for our Medicare enrolled beneficiaries to a Medicare account and receive monthly reimbursement from the Social Security Administration for our costs, both direct and indirect.

There are several advantages to this arrangement. For the physician or clinic the administrative conveniences are significant. The beneficiary, since we pay all coinsurance and deductibles, never has to become involved in the payment cycle. From a systems perspective, the arrangement is particularly attractive in that all of our beneficiaries, Medicare eligible or not, have a single level of coverage, and the subtle incentives toward two levels of care that may be caused by two reimbursement mechanisms are nonexistent.

The legislation you are considering today, S. 708, to extend Medicare reimbursement to small rural health clinics that use physician extenders to provide primary care, is consistent with our institutional goals of accessible, quality care at a reasonable cost. This legislation, however, has some underlying assumptions for medical practice in general that, in our view, have sound, but perhaps unpopular implications. The most significant of these is the emphasis on a cost based rather than fee-for-service reimbursement mechanism. The emphasis on utilization review, on explicit linkages between primary and secondary care, and finally the emphasis on certification of physician's assistants and the supervisory responsibility of the physician are also noteworthy.

One aspect of this legislation, however, causes us concern: the establishment of a different mechanism for reimbursement for physician's assistants' services in rural and non-rural areas. While there may be many valid reasons for this distinction, there is the danger that, rather than developing different ways of purchasing the same product, you may, in truth, be purchasing two standards of care, and unwittingly be creating the same kind of disincentive to rural practice for physician's assistants that has been created for physicians under the "usual and customary" regulations of Medicare.

Let us be candid: This Congress and this Administration have made it abundantly clear that the top two priorities in health programs, particularly

Medicare, are controlling costs and eliminating fraud and abuse. While accessible quality care is also a great concern, any proposal such as this legislation to improve accessibility and quality, must be defended in terms of what it will do to costs and what is the potential for fraud and abuse.

As a third party providing a very broad range of benefits with no coinsur-

ances, deductibles, or limitations on extent of coverage, with a pre-established and fluctuating income, let me assure you we fully share these priorities.

Let us examine the key aspects of this legislation from our experience in

purchasing care through systems utilizing physician's assistants.

COST-BASED REIMBURSEMENT

The Funds have long favored cost-base reimbursement arrangements with physicians, clinics, and hospitals. Because the collectively-bargained benefits do not "lock" our beneficiaries into a single provider or health care system, we have not entered capitation arrangements. Instead, we attempt to develop with our larger providers a cost-based fee-for-time or retainer payment. Simply stated, if a clinic or group has a Funds "approved" annual budget of \$1,200,000, and one-half of their patient encounters are with our beneficiaries, then we pay them \$600,000 a year or \$50,000 each month. They provide us with a detailed invoice of beneficiaries seen and services rendered but no fees are associated with each service.

Over the years we have learned several important things about cost-based arrangements. First, you must be explicit about what you will allow, and

in so doing, you must take into account these factors:

Market place compensation for all personnel, including incentives.

Distribution of personnel and resources: is the array of physician to nonphysician personnel appropriate and have the questions of where and how to provide ancillary services been answered in a tough, cost-effective manner. A physician in solo-practice will send the majority of his lab work to a commercial laboratory, often many miles away, and yet when he or she moves their practice to a non-profit community clinic they expect, and often receive, on-site laboratory services that are extremely costly and questionably more valuable than those from the centralized commercial facility.

Productivity. Unfortunately, without some built-in productivity standards or incentives, cost-based reimbursements tend to dramatically reduce productivity. This is an extremely difficult area because of the failure of the health care system to measure outcomes: We measure cost per encounter and not cost per episode of illness. We are now beginning to accumulate data on this, but in the interim we look for some standard of productivity based on

encounters.

Recruitment, professional development and continuing education (or, funded depreciation for personnel). Here we look to medical records, chart review, seminars, continuing education, and recruitment.

Depreciation of plant and equipment.

"Profit" Sharing. (Dollars saved in the total health system should be partially distributed to those who influence the savings). This is a relatively new area for the Funds. Conceptually borrowing from the HMO concept, we are attempting to get our outpatient providers to assume some shared risk for hospital utilization.

Essential to any cost-based reimbursement plan is the concept of prospective payments. Although S. 708 does not rule out prospective payments, it also does not require it. We feel prospective reimbursement is the only way to put the managerial responsibility where it belongs, in the health delivery system. The public has long been outraged at cost overruns in the defense industry; they should be equally appalled at the retrospective payment practice in the health industry.

While we fully appreciate that S. 708 is designed to remedy a specific inequity in Medicare's reimbursement for the services rendered by physician's assistants, we strongly endorse prospective cost-based reimbursement ar-

rangements on a broader scale.

What are the administrative problems and costs associated with cost-based reimbursement mechanisms? Our experience has been that without specific policies and procedures and, without an adequate data system, cost-based arrangements can be difficult to develop and monitor. Historically the Funds

concentrated its cost-based reimbursement program on hospitals and larger clinics and group practices. In recent years these arrangements were broadly extended to individual physicians and small groups. We are now moving back to fee-for-service with these providers because our administrative staff could not effectively negotiate and monitor cost-based arrangements with our

more than 16,000 billing providers.

Despite this experience, we think the administration of cost-based arrangements can be simplified so as to be manageable on a large scale. Specific reporting formats must be designed, policies on allowable costs must be clearly articulated, productivity standards set, and audit requirements explicitly stated. If this is done effectively, the reimbursement mechanism can be simplified through what we refer to as register billings, and the administrative savings on the reimbursement mechanism can be used to manage the "frontend" of a cost-based reimbursement mechanism.

It is our experience that the requisite accounting talent is readily available in most rural communities, and compliance with a rational set of cost ac-

counting procedures should provide no difficulty to most providers.

QUALITY CONTROL

Moving from the question of cost-based reimbursement to the issue of the supervision and control of the quality of the physician's assistants' practice, the Health and Retirement Funds strongly endorse those provisions of this legislation requiring regular review by the supervising physician, utilization review procedures, certification of the physician's assistant, and explicit ar-

rangements between the hospital and the clinic.

While we have supported the use of physician's assistants in a number of settings, we are firmly opposed to the concept of independent practice. Recent positions taken by the American Nursing Association suggesting the relationship between the physician and the nurse practitioner should be collegial, not supervisory, are totally unacceptable to us and, in our experience, to physician's assistants. The fact that in some rural communities, physician's assistants must practice without a fulltime physician present is an unfortunate by-product of our national maldistribution of physicians. While we feel this legislation adequately assures a quality practice of the physician's assistant, it should not be interpreted as the beginning of a movement toward independent practice of physician's assistants.

While the span of supervisory control is not explicitly addressed in this legislation, it may be appropriate to consider, particularly, in view of the broader concern of fraud and abuse. We would not object to a limitation of two physician's assistants for each physician supervisor.

The emphasis on utilization review is another attractive feature of this legislation. We would assume that the intent here is to require some mechanism for examination of both outpatient and inpatient utilization. The Funds are now developing ways of monitoring ambulatory care for both the appropriateness and cost of treatment. Although the motivation for utilization review in this legislation is to assure that the care rendered by physician's assistants in settings that lack full time physicians is of a high quality, it is our view that utilization review of ambulatory care as well as inpatient care is something that should be a priority for all third parties, including the federal government.

As noted, we also strongly favor the provision of this legislation that requires that the clinic have "arrangements with one or more hospitals for the referral or admission of patients . . .". This provision not only assures that patients will have accesses to secondary care without the direct intervention of a physician, but also implies that the interface between primary and secondary care will be constructed in such a fashion as to limit unnecessary

admissions.

Because physicians have historically moved freely between outpatient practice and inpatient care, little attention has been given to coordination of these two parts of our health care system. Recent efforts by Medicare and PSROs to standardize criteria for both admission and length of stay are

laudable, but primarily serve a gate keeping function rather than an integrating function between primary and secondary care.

We would hope that, if passed, regulations covering this provision of the

legislation would convey this emphasis.

ONE REIMBURSEMENT MECHANISM FOR PHYSICIAN'S ASSISTANTS OR TWO

Earlier, we expressed concern that this legislation, through a unique arrangement for the reimbursement of physician's assistants in rural clinics, might foster two standards of care or create disincentives to rural practice for physician's assistants. As we have noted, the U.M.W.A. Health and Retirement Funds have endeavored to develop one standard of care for all beneficiaries. With regard to physician's assistants, although we favor cost-based reimbursement, in those practices where we pay on a fee-for-service basis, we pay for the physician's assistants' services as though they were the physician's. We do this because, through supervision and consultation we believe the services are the same.

Moving from this premise, we would urge consideration of a single mechanism for reimbursement of physician's assistants without regard to the community in which they practice. As noted, we think a prospective cost-based

reimbursement is preferable.

Beyond the inherent deficiencies of a two tiered system, are the real difficulties in definition of rural and medically underserved areas. I have actively participated in several efforts over the past two years to come to a workable definition of rural medically underserved areas. I can assure you there is no consensus on this problem.

Obviously, expanding Medicare coverage to clinics using physician's assistants without full time physicians to urban areas must raise concern about both escalating costs and fraud and abuse. Those concerns must be adequately answered. Since our experience is not in urban health care, we cannot address

these concerns.

In summary, the U.M.W.A. Health and Retirement Funds fully endorse the extension of Medicare reimbursement for physician's assistants to rural clinics operating without full time physicians. We strongly endorse a cost-based reimbursement, but would urge that it be prospective. We strongly endorse the level of supervision and quality control proposed and would oppose any dilution of that to a collegial relationship. We have some concern about yet another differential between rural and urban medicine and would ask that a single alternative be explored.

STATEMENT OF OLIVER R. FIFIELD, PRESIDENT, NEW HAMPSHIRE-VERMONT BLUE CROSS-BLUE SHIELD, CONCORD, N.H.

More than a year ago, I was contacted by Senator Leahy and Mrs. Elizabeth Davis, Executive Director of the Visiting Nurse Association of Chittenden and Grand Isle Counties in Vermont. Following a discussion with Mrs. Davis, Blue Cross-Blue Shield agreed to participate in an experimental program to reimburse for the services of nurse practitioners at the Champlain Island Health Center.

We have been aware for some time that the resident physician who supplied all primary health care in Grand Isle County was planning to retire. The County and Island, as you perhaps know, are rather isolated and yet there are opportunities for high-quality health care within 30 or 40 miles. New Hampshire-Vermont Blue Shield has, over the years, provided a wide range of surgical, medical and diagnostic benefits for care outside of the hospital setting. Most subscribers have coverage for home and office calls, in some cases without a deductible, but usually with a two-call deductible each calendar year for a Plan member. Similarly, x-ray and laboratory costs are also

covered after an annual \$10 deductible.

A member of our staff, Mr. Albert Phipps, was assigned to work with Mrs. Davis to develop a pilot program. They concluded that in order to test the result of providing as wide a range of coverage as possible for the services of nurse practitioners, Blue Shield would not require payment of the first

two office calls, nor would it require payment of the \$10 deductible before benefits became available. We would, in effect, provide coverage for all medical and laboratory services provided at the Champlain Island Health Center for

Blue Cross-Blue Shield members.

Our approach and strategy was to limit the amount of record keeping and keep claims processing to an absolute minimum. At the same time, we hoped to capture sufficient data to be able to measure, from our point of view, the usefulness and cost advantages of this approach to primary health care. Our contract (see attached) which was signed by the Visiting Nurse Association August 13, 1976, provided for a six-month pilot program. Blue Cross-Blue Shield pays monthly based on a listing of services (copy attached)—\$4.00 for a routine medical visit, and \$8.00 for an extended visit, laboratory charges and other covered services as billed by the Health Center. At the end of the six-month period, we have agreed to audit the costs incurred by the Health Center and reimburse them the actual cost of service based on the proportion of services provided to Blue Cross-Blue Shield subscribers. Although that audit has not been performed as yet, attached is a copy of a five-month summary of activity. Obviously, it is too soon to evaluate the success or failure from our point of view of the Health Center. However, based on our experience to date, it is our intention to renew our agreement with the Visiting Nurse Association for another six months.

You will be interested to know that the listing on which we are billed each month contains sufficient information to allow its use as our claim form, internal history, and an invoice for our financial record supporting payment to the clinic. In fact, we generate no other paper except a check and three

photocopies of the listing in our office.

It is a well-known fact in our area that physicians are not going to rural communities to replace older physicians who are retiring. The number of new physicians in Vermont has increased dramatically in the past few years; yet the smaller communities are not able to attract resident physicians. It is our opinion that the nurse practitioner represents the most practical approach to providing primary care and, therefore, access to the health care system for people in rural areas. We have enrolled approximately 50% of the population of Vermont in Blue Cross-Blue Shield. Nonetheless, the support of the federal and state governments is needed in order to make projects like the Health Center practical for people in rural areas. Support by providing benefits through the Medicare and Medicaid programs is absolutely necessary to the success of rural health clinics such as the Champlain Island Health Center.

IN SUMMARY

Blue Cross-Bule Shield is participating in this experiment for three reasons:

1. To test this approach to health care in rural areas from a cost contain-

ment point of view.

2. We believe the availability of health care in rural areas will provide more equity and better distribution of our premiums among the subscribers and thereby encourage enrollment of additional members.

3. We believe Blue Cross-Blue Shield has a community responsibility to participate and encourage more effective ways of delivering health care.

My personal opinion is that members of Congress should encourage the development of community health centers in rural areas staffed by nurse practitioners. I have read Senate Bill 708, and I believe it represents a key step forward in the encouragement of better health care at a reasonable cost in the rural communities of our country.

Thank you for this opportunity to speak to your committee.

Enclosures.

BLUE SHIELD NURSE PRACTITIONER REIMBURSEMENT CONTRACT

VISITING NURSE ASSOCIATION, INC. (CHAMPLAIN ISLANDS HEALTH CENTER) PROVIDER

THIS AGREEMENT made and entered into this 13th day of Aug., 1976, by and between the NEW HAMPSHIRE-VERMONT PHYSICIAN SERVICE,

a non-profit organization of the State of New Hampshire, having its principal office in the City of Concord, New Hampshire, hereinafter called Blue Shield and Visiting Nurse Association, Inc., having its principal place of business in Burlington, State of Vermont, hereafter called the Provider.

WITNESSETH, that Blue Shield and the Provider, each in consideration of the promises of the other, contract as follows:

Ι

SERVICE PROVIDED

The Provider agrees with Blue Shield that it will furnish care to Participants of New Hampshire-Vermont Blue Shield in accordance with Subscriber Certificates as issued and as amended from time to time. This Contract is to be for a period of six (6) months starting September 1, 1976. The intent of this pilot program is to study methods of health care delivery.

II

UNIFORM REPORTING AGREEMENT

1. The Provider agrees to furnish to New Hampshire-Vermont Blue Shield such financial and statistical data as is required to compile cost analysis of the Provider's operation. All such data shall be reported on the accrual basis unless otherwise agreed upon by Blue Shield and the Provider and shall reconcile to the Provider's annual audited financial statement and shall be subject to verification by Blue Shield upon request by examination of the Provider's books and records.

2. The Provider agrees to submit an annual operating budget sixty (60) days before the beginning of its fiscal year for review and evaluation and

acceptance by Blue Shield.

3. The Provider agrees to furnish Blue Shield with quarterly operating statements showing comparisons of budget to actual and in sufficient detail to enable New Hampshire-Vermont Blue Shield to prepare a cost analysis consistent with the terms of this contract.

III

BENEFITS TO BE PROVIDED

1. New Hampshire-Vermont Blue Shield agrees to reimburse the Provider for those services provided our subscribers that are covered under the Blue Shield Basic Contract. Such services shall consist of medical calls, necessary

laboratory work and will not cover drugs, screening, counseling or social work.

2. New Hampshire-Vermont Blue Shield will make payments to the Provider upon receipt of ledger billings from the Provider, based upon current charges. There will be a cost settlement at the end of the six (6) month pilot study, and the final settlement will be made in the manner that will result in the Provider receiving no amount greater than their actual cost of providing covered services to New Hampshire-Vermont Blue Shield subscribers. Such amount not to exceed 125% of approved budget except by mutual agreement in such proportion as Blue Shield subscribers relate to the whole.

3. The settlement of each six (6) month period will set the rate of reim-

bursement for the next six (6) month period, if both parties agree to renewal

of contract.

4. This Agreement shall terminate six (6) months from September 1, 1976, or may be terminated by either party upon thirty (30) days prior written notice to the other; and, in the event of such termination, the obligation of the Provider to render service shall cease.
IN WITNESS WHEREOF, the Parties to this Agreement have caused the

same to be executed by their duly authorized officers, the day and year first

written above.

CHAMPLAIN ISLANDS HEALTH CENTER—BUDGET FISCAL YEAR 1976 (JULY 1, 1976, TO JUNE 30, 1977), HEALTH
CENTER PATIENT CARE EXPENSES ONLY

	Expenses	Expense
. Personnel:		
Project director	\$2, 100	
Assistant project director	5, 100	
Nurse practitioner I, 100 pct	13, 424 4, 650	
Nurse practitioner II, 50 pct Nurse practitioner III, 10 pct	1, 050	
Paramedic clerk, 100 pct	6, 200	
Secretary, 100 pct	7, 128	
Bookkeeper, 25 pct	3,000	
Total	42, 652	\$42,65
Physician's fees	8, 400	8, 40
Operational expenses:		
Laboratory and diagnostic	1,600	
Medical supplies		
Office suppliesTransportation		
TransportationRent (including heat)		
Communication expense (telephone, postage)	1, 900	
Insurance		
Statistical and accounting		
Miscellaneous	1,000	
Total	13, 757	13, 75
Total projected expenses	-	64, 80

[Memo]

Re Grand Isle County Health Council, Inc.

To: D. Parker. From: A. Phipps.

Date: February 9, 1977.

Dave, here is a five-month review of the Nurse Practitioner Pilot Study that was set up with the Visiting Nurse Association, and the Grand Isle County Health Council, Inc. to reimburse for medical services and associated laboratory work provided our Blue Cross and Blue Shield subscribers by Nurse Practitioners at the Grand Isle Health Center.

This pilot was set up on a cost or charge basis and covered services consists of medical calls and necessary laboratory work. Drugs, screening, counseling

and social work are not covered.

BLUE SHIELD PAYMENTS

	Total all visits	Blue-Cross- Blue Shield patient contacts	Medical calls	Laboratory paid	Total
September 1976	243 271 320 289 277	32 36 43 36 32	\$158 178 259 158 187	\$20.50 35.00 19.00 20.50 15.00	\$178.50 213.00 278.00 178.50 202.00
Total	1, 400	179	940	110.00	1,050.00

12.78 pct of patient visits were Blue Shield

There are several points of interest that I would like to draw to your attention:

1. Brief office visits (\$4 or less)	76
Extended office visits (\$8)	90
2. Lab procedures:	
Blood work	8
Throat cultures	32
Urine work	2
Pap	4
3. Number of patients that had home and office coverage:	
Y rider	50
W rider	27
Indemnity home and office	91
No home and office coverage	11

Dave, on the basis of five months experiences, I feel that this pilot study contract should be extended for another six months. The cost is reasonable, ledger billing is workable and should be expanded, and this system certainly provides a point of entry for our subscribers into the health care system and should be explored further.

STATEMENT OF RALPH BORSODI, REPRESENTING NATIONAL RETIRED TEACHERS ASSOCIATION, AND AMERICAN ASSOCIATION OF RETIRED PERSONS

I am Ralph Borsodi, a retired economist and consultant to the 10.2 million member National Retired Teachers Association and American Association of Retired Persons. Our Associations support the passage of S. 708, a bill designed to provide Medicare reimbursement for the services of physician extenders in rural areas. The enactment of such a measure should prove to be a significant driving force which will increase the availability and improve the accessibility of primary care services for Medicare beneficiaries who reside in rural areas.

Census data gathered in 1970 indicate that a substantial number of persons aged 65 and over live in rural parts of the nation. The figure at that time exceeded five million individuals. The continuing migration of some younger persons from nonmetropolitan to metropolitan areas accompanied by the reverse migration of some older persons are forces which will maintain this fairly high number of aged individuals who live in rural areas.

These regions are usually characterized by a relatively small distribution of health professionals and facilities compared to urban areas. For example, the latest Department of Health, Education and Welfare Five Year Forward Plan states that in 1974 there were approximately 199 nonfederal physicians providing patient care for approximately every 100,000 individuals living in the largest metropolitan areas.*

The ratio for small nonmetropolitan areas was 40 per 100,000. Indeed, there are some counties that are without physicians, dentists, nurses, pharmacists, and hospitals. Superimposed upon these population and health resources statistics are other important considerations. In terms of demography, the 65 and older age group is growing at an unprecedented rate. This circumstance requires increasing federal outlays for health protection. The most dramatic increases are occurring among the 75-plus and 85-plus age groups which are growing at rates of two and three times that of the total population. An increase in health problems and a greater need for health services usually correlate with this advancement in age.

Juxtaposing these conditions raises a troublesome policy issue. Rural areas are inhabited by a large number of older persons. Compared to younger groups, the aged have more health problems which often include a greater degree of incapacitation. Regrettably, there do not seem to be sufficient health resources available in these locations to deal sufficiently with the extent of the problem.

^{*}Forward Plan for Health FY 1978-82, U.S. Department of Health, Education, and Welfare, August 1976.

NRTA/AARP look upon proposed legislation to provide Medicare reimbursement for the services of physician extenders as being consistent with our over-all legislative objectives. While we have long articulated the need to make important changes in the Medicare program, we recognize that the structural underpinnings of this country's system for financing health care need to be modified.

The excessive inflation in the health care sector cannot continue unabated without having serious consequences. Until this unprecedented growth in expenditures is curtailed, it is unlikely that there will be any expansion of existing benefit packages. Instead, there is the threatening prospect that current benefits under Medicare and Medicaid might have to be reduced as a

way of slowing down the inflation in these programs.

Meanwhile, the out-of-pocket costs of older persons for health care grow larger each year. In fiscal year 1975, the average health care expenditure for persons 65 years and over amounted to \$1,360. Of this amount, the direct payment made on a per capita basis by the aged was \$390 or 28.7 per cent of the total. These payments represented the cost of items such as the following: drugs, routine dental and eye care, other preventive services, nursing-home care, unassigned physicians' charges in excess of the carriers' reasonable charge determinations, deductibles and coinsurance payments.

The various deductible, coinsurance and copayment features of Parts A and B of Medicare are evenly imposed on all beneficiaries. Such uniform cost sharing discriminates against low income persons and in some cases may act as a disincentive to their seeking necessary health care. Even though states have buy-in agreements through their Medicaid programs, the medically

indigent are not always covered.

Residents of rural areas are discriminated against in another important way. Because of the relative paucity of physicians, sometimes the only care which may be available is that provided by physician extenders in rural clinics. Yet, the Medicare law does not recognize these providers for purposes of reimbursement. Thus, a situation has been created in which a large group of beneficiaries is contributing to the costs of the program without having equal access to all its benefits. It is our position that steps should be taken to correct this inequity by providing reimbursement to clinics which offer care provided by physician extenders.

We also recommend that a more equitable payment system be established for Medicare beneficiaries. It was just indicated that low income persons feel the impact of the \$60 deductible, the monthly premiums, and the 20 per cent co-payment aspects of Medicare more severely than higher income persons. The current premiums alone amount to \$86.40 per year. A scheduled hike in July will increase this to \$92.40 annually. The combined effect of these fees needs to be lessened to guarantee that no aged individual will be deterred

from seeking health care because of insufficient personal resources.

Inhabitants of rural areas are at a disadvantage in a second important way. Access to health services often involves travel over considerable distances. The gradual reduction of bus systems in small towns and the absence or high cost of taxis have made it difficult to travel unless an individual either owns a private automobile or cau obtain the use of one. Time, search, and transportation costs pose barriers to obtaining health care.

Since overcoming these obstacles is a considerable challenge in itself, we advocate that steps be taken to alter the present payment system as a way of reducing one of the major disincentives which may stand in the way of obtaining care. The deductible and premiums should be eliminated. Copayments for services should be related to one's ability to pay for them.

payments for services should be related to one's ability to pay for them.

Related to this issue is the failure of the Medicare program to protect patients from physicians' charges in excess of the carriers' reasonable charge determinations. The percentage of claims and the percentage of charges reduced have been steadily increasing for both assigned and unassigned claims. These increasing cost differentials have to be assumed by patients.

As a way of correcting this inbalance, NRTA/AARP recommend that the system of retrospective reimbursement of providers on the basis of reasonable charges be changed. This method of paying for services has led to higher

² Gornick, Marian. Ten Years of Medicare: Impact on the Covered Population, Social Security Bulletin, July 1976.

rates of inflation and unnecessary expenditures while providing less financial protection for patients.

Instead, our Associations favor a system of prospective reimbursement. Unlike retrospective systems, a prospective system provides a greater opportunity for providers and payers to project outlays more accurately. It should

also allow for more effective administrative control.

The Medicare program should pay a percentage of a rural clinic's predetermined budget on the basis of the percentage of services rendered to Medicare beneficiaries. Additionally, each clinic should have a community governing or advisory board. Older persons should be present on such boards. One way of judging the extent to which they might be represented would be to look at the percentage of clinic services which they use. This same percentage could then be applied to determine their proportional representation.

The most costly form of health care is that provided by hospitals. If patients do not have access to rural clinics, it is inevitable that they will eventually travel to hospitals when their health problems become serious. It is our belief that these clinics can reduce hospitalization. In light of the present need to control costs, it is imperative that less expensive types of

care be made available in the form of these clinics.

Medicare reimbursement for the services of physician extenders in rural clinics should provide the stimulus necessary to keep existing clinics in operation. It should also help to remove barriers which impede the establishment

of new clinics in medically underserved areas.

Another observation worth listing is the need to introduce some degree of consistency into our nation's health policy. It makes little sense for the government to fund health manpower training programs unless there is a commitment to use the services of those who are the products of these programs. Since public monies are currently being used to support the training of physician extenders, it only follows that government programs such as Medicare should recognize this fact by reimbursing the services provided by these extenders.

The present Medicare program is deficient in other important respects. The major focus is on curative rather than preventive care. Our Associations would like to see an expansion of the basic benefit package so that additional services are covered. Routine physical examinations, immunization against influenza, and nutritional counseling are examples of items that need to be

included among the present array of services.

Health education should be reimbursed on a more formal basis. Unlike their urban counterparts, residents of rural areas do not have equivalent access to accurate health information. Deeply ingrained false beliefs coupled with cultural and language barriers in various parts of the United States may deter certain individuals from seeking care. Under these circumstances, health education is a matter of necessity. Significant cost savings may also be involved, since it is often easier to treat disease in its early rather than late stages.

Our Associations have been highly active in the health education field. During the last four years, we have conducted thousands of programs and reached hundreds of thousands of older persons. Our latest initiatives have

been in the area of screening.

This year, we are conducting a pilot colon-rectum cancer screening program in Missouri and expect to have a national program within the next one to two years. An endometrial cancer screening program is in the planning stage. Based upon last year's success in a pilot high blood pressure screening program, we are now in the process of developing a national screening program in conjunction with our existing educational program on cardiovascular health.

Two points should be noted at this juncture. The first is that our Associations have a limited capacity to reach older persons through direct contact despite the large number which we have already reached. The second is that our programs are in great demand in rural areas. This testifies to the need to develop additional ways of providing health education to the residents of these areas. Using the services of physician extenders in rural clinics provides an excellent means of doing so. Based upon our experience, we know that this need exists. That is why we urge that such activities be reimbursed directly by Medicare.

In conclusion, NRTA/AARP are in favor of Medicare reimbursement for the services of physician extenders in rural parts of this nation. Apart from whatever savings may result from doing so, we believe that on the basis of fairness alone rural residents who happen to be Medicare beneficiaries are entitled to a share of the services for which they pay. Their health needs are considerable and it is our position that such needs should be met without further delay. Our Associations support Senate Bill 708 and will work toward its enactment.

STATEMENT OF ARCHIE S. GOLDEN, M.D., CHAIRMAN, GOVERNMENT RELATIONS COMMITTEE, ASSOCIATION OF PHYSICIAN ASSISTANT PROGRAMS

Mr. Chairman and members of the committee: I am Dr. Archie S. Golden, Chairman of the Government Relations Committee of The Association of Physician Assistant Programs. I am here today to offer testimony on S. 708 and the Medicare reimbursement system. I am Associate Professor and Director of The Health Associate Program at The John Hopkins University School of Health Services. Also, I am Associate Professor of Pediatrics at The Johns Hopkins School of Medicine and Associate Professor of Maternal and Child Health at The School of Hygiene and Public Health.

I am pleased to have this opportunity to testify on behalf of the 50 physician assistant training programs in this country. I am accompanied by Dr.

Donald W. Fisher, Executive Director of the Association.

MEDICAL CARE AND THE PHYSICIAN ASSISTANT IN THE UNITED STATES

The United States Congress has, in the past six years, actively promoted the training and development of physician assistants (PAs). The Comprehensive Health Manpower Training Act of 1970 was responsible for the development of 42 physician assistant training programs whose graduates would assist primary care physicians by providing routine medical and health care services in underserved areas. The Health Professions Educational Assistance Act of 1976 authorized continuation of federal support for physician assistant programs. It should be pointed out that the U.S. Department of HEW has funded physician assistant training and research to an amount

over 48 million dollars.

The Congressional support, cited above, coupled with organized medicine's recognition of the need for formally trained assistants, has been responsible for the training and development of physician assistants. In 1970; the American Medical Association defined the physician assistant as ". . . a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant." In 1971, Educational Essentials(1) were jointly developed by the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, the American Academy of Physician Assistants, and the American Society of Internal Medicine. Through this accreditation mechanism, more than 50 programs have been accredited to date. In 1973, the National Board of Medical Examiners administered National Certifying Examinations and continues to do so under the auspices of the National Commission on Certification of Physician's Assistants. Over 40 states have enacted legislation providing for the practice of physician assistants with legislation currently proposed or pending on the remaining states. In 1973, the Secretary's Commission on Malpractice stated that the then growing concern over malpractice should not be a deterrent to the utilization of physician assistants.

PHYSICIAN ASSISTANT IMPACT

Economics of care

Educational cost data from the National Center of Health Services Research (NCHSR) on physician assistants show the education cost to be 15,100 dollars per year(2). The cost of producing a physician assistant is less than ¼ that of preparation of a graduate physician(3). Wert's(4) data shows that a PA can provide 2.6 years of physician equivalent services before a physician who simultaneously began his medical education can begin prac-

tice. Moreover, $\operatorname{Record}(5)$ estimates a saving of $20,000/\operatorname{PA/year}$ in an HMO setting. Peterson(6) and his colleagues have shown very significant reductions in hospitalizations through the use of PA staffed ambulatory care clinics in a major V.A. Hospital.

Access to care

Record(7) and Hill(8), in separate studies, have shown that the outputs of primary care services are similar for both physicians and physician assistants. Moreover, Scheffler(9) and Fisher(10) report wide distribution of PAs throughout all 50 states with a majority of PAs in primary care settings. 60 percent of PAs are in communities of less than 50,000. For example, in Oklahoma, 62.2% of program graduates are in communities of less than 25,000; in Utah, 72% of program graduates are in communities of less than 25,000, and in Washington, 57.7% in communities of less than 20,000. Also, significant numbers of physician assistants are working in inner city areas. The recent health manpower legislation not only authorizes funds for physician assistant training and National Health Service Corps Scholarships, but also requires that part of each Area Health Education Center include training for physician assistants or nurse practitioners. Also, it appears that the Health Resources Administration has decided that new funding for these centers will be directed at inner city urban areas.

Quality of care

Numerous studies, Nelson (11), Pondy (12), Henry (13), and Norbrega (14), have shown that job acceptance, as a function of quality, is highly favorable. For example, Nelson found that more than 85% of patients rate PAs as highly competent and professional, and 71% report improvement in the quality of care. Record reports no significance differences in morbidities or outcomes in primary care services delivered by MDs and PAs. More importantly, B. J. Anderson, J.D. (Staff, American Medical Association Legal Council) stated that as a result of decreased waiting time, increased accessibility to professional care and overall patient satisfaction, it appeared that the inclusion of a physician assistant in a practice was an excellent deterrent to the ever present threat of malpractice.

In sum, a review of available research shows that the physician assistant concept has been successful in addressing the three major issues confronting the nation's system for health care: (1) a reduction in cost, (2) an im-

provement in access, and (3) the delivery of high quality care.

THE IMPEDIMENT: MEDICARE, PART B

In spite of evidence that the physician assistant concept has been successfully addressing major national health problems, further deployment of physician assistants into underserved areas is being seriously impeded by the current Medicare Law (Title XVII (Section 1861(s)(2)(A))), its rules and regulations.

Excerpts from the Medicare Act and Part B, Intermediary Manual reveal

the problem:

Title XVII Sec. 1861(8)

"The term 'Medical and Other Services' means any of the following items or services . . . (2)(A) Services and Supplies . . . furnished as an incident to a physicians' professional service, of kinds which are commonly furnished in physician's offices and are commonly either rendered without charge or included in the physician's bills . . .".

Part B Intermediary Manual, Sec. 6103(B)

"... there is no provision under Part B which authorizes coverage of the services of physician assistants as independent practitioners, the only basis for covering their services under Part B would be as services furnished incident to a physician's professional service and one of the ... requirements ... for services to be covered under this provision is that they must be of kinds that are 'commonly furnished' in physicians' offices. Thus, the performance by a physician assistant of services which traditionally have been reserved to physicians cannot be covered under Part B even though all the other 'incident-to' requirements are met".

The current attention drawn to the "non-reimbursement" policy has had negative impacts in rural underserved areas of this nation. Without reimbursement for services performed by physician assistants practicing in areas with large numbers of Medicare recipients, physicians cannot afford to employ a physician assistant even though the potential benefits to patients is well recognized. Physicians have had to sharply curtail the utilization of their PAs when Medicare would not reimburse the employing physician for their services. Many program directors fear that their graduates will be forced into affluent suburban or institutional practices because the employing physician cannot be reimbursed for services safely and legally delegated. Most importantly, many Medicare recipients are having to pay for the delegated

services out of their meager incomes.

In summary, in the past decade, we have seen the development of a new health profession with an accreditation mechanism which is recognized by the Office of Education (DHEW); certification mechanisms through the National Commission on Certification of Physician's Assistants and legislation in 40 states granting statutory recognition for this profession. The evidence exists that physician assistants may reduce the physician's risk of medical negligence by improving the continuity of care. Research does exist which confirms excellent patient acceptance by physicians, that physician assistants are improving access to health care by practicing in geographical areas deficient in health manpower, physician assistant productivity-within their role—is comparable to physician productivities, and that the potential for reducing the cost of health care is present with the utilization of physician

assistants.

RECOMMENDATIONS

The Association of Physician Assistant Programs recommends that Title XVIII of the Social Security Act, Part B Supplemental Medical Insurance (42USC1305), and all such other medical entitlement program be amended to permit reimbursement for physician assistant services in the following way:

(1) cost reimbursement to specific health clinics in medically underserved

rural areas.

(2) for other underserved areas, to attract providers to practice in these areas, that reimbursement be to the physician at usual and customary rates,

(3) and, for all other areas, taking into consideration cost control, there would seem to be room for discussion to come up with an amenable reimbursement rate.

Also in order to put to rest concerns relating to quality of care, fraud and abuse, reimbursement should only occur when the following criteria are met:

(1) The practice of the physician assistant is not in conflict with the laws

of the state in which the services are provided.

(2) The activities and patient care services by physician assistants shall be provided under the responsible supervision of (a) licensed physician(s). Services of physician assistants shall include services performed regardless of whether the physician was actually present and regardless of whether the services were performed in the physician's office, or at some other site. That a physician supervise no more than two physician assistants.

(3) Physician assistants be defined as individuals who have completed an

educational program for physician assistants accredited by the American Medical Association or other recognized accrediting agency and/or are holders of current certificates from the National Commission on Certification of Physician's Assistants.

We feel that it is necessary and justifiable to apply the reimbursement on a nationwide basis.

Potential costs of nationwide reimbursement

We understand and share the concern of Congress about escalating health care costs. At present, we have an economist working on the question of the cost of reimbursing physician assistants nationwide and will have more exact information within two weeks and would be pleased to share that information with this committee. However, the U.S. Department of Health, Education and Welfare has developed some estimates taking into consideration physician income, number of Medicare patients, the increased intensity of care for older people and deductibles. From this they estimate the cost of Medicare reimbursement to be 1,782 dollars per physician utilizing a physician assistant or nurse practitioner per year. Since there are about 5,000 physician assistants practicing with adults, the total cost would be 8.9 million dollars. If one adds the approximately 3,000 nurse practitioners practicing with adults, the reimbursement nationwide would come to 14.3 million dollars. This is not a large amount and, in fact, it appears that close to three quarters of that amount is in reality being reimbursed today to physicians employing these new practitioners, although not covered within the Medicare rules and regulations.

Therefore, we estimate that the net increase for nationwide reimbursement

would not be higher than 3.6 million dollars.

We feel that limiting reimbursement to only rural health clinics or only rural areas denies just payment to practices in many urban areas where important contributions to health care access are being made by physician assistants. In fact, there is a danger that the organizational mechanism necessary to administer such categorical reimbursement as only rural clinics or only rural areas may cost as much as the reimbursement itself.

We note that on page 58 of President Carter's FY 1978 budget revisions released on Tuesday, February 22, 1977, related to proposed Medicare legislation, there were estimated outlays of 25 million dollars which would promote the availability of primary and rural health care by extending cost reimbursement to nurse practitioners and physician assistants practicing in rural

health clinics.

We feel that this amount of money would more than cover reimbursement

nationwide under Medicare Part B for all physician assistants.
We recommend that S. 708 entitled "A Bill to amend title XVIII of the Social Security Act to provide payment for rural health clinic services" be adapted to provide for reimbursement for services provided by physician assistants and nurse practitioners throughout this country.

We believe that nationwide reimbursement is a necessary step not only to facilitate distribution of services and contain costs, but also to take us on the road toward equal rights for health care for all people of this country.

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STATEMENT OF LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Leo J. Gehrig, M.D., Senior Vice President of the American Hospital Association. With me is Mr. Fred E. Mondragan, Regional Administrator, Presbyterian Hospital Center, Albuquerque, New Mexico. The Association represents over 6,500 health care institutions (including most of the hospitals in the country; extended and long-term care institutions; mental health facilities; and hospital schools of nursing), and over 24,000 personal members. We appreciate this opportunity to share our views and recommendations on your bill, S. 708. While our Association supports the intent of this legislation to provide Medicare payment for certain services rendered in rural health clinics, we would like to offer for the Subcommittee's consideration some constructive suggestions for improvement of the bill.

BACKGROUND

The American Hospital Association has long recognized the need for innovative use of new and existing categories of health care professionals other than physicians to provide needed health care services in areas where primary care physicians are either unavailable or are insufficient in number to satisfy medical care needs. The AHA has encouraged the training and appropriate use of such health care personnel in order to make health care services more widely accessible, to extend the services of physicians by utilizing their time more efficiently, and to enhance the quality of medical services.

The Association is one of the founders and participants in the National Commission for Certification of Physician Assistants along with 17 other health care organizations. We have supported the use of these health care professionals in our hospitals and have disseminated recommended institutional procedures and guidelines for physician extenders in the hospital setting.

The Congress also has recognized the importance of the effective and efficient use of health manpower resources. Through enactment of the Health Professions Educational Assistance Act, funds are provided to schools of public health and allied health as well as scholarship and loan programs for students preparing for careers as health care providers, but not as physicians. Training programs of the military services have also been important sources of such personnel.

We would like to make a general observation at this point in order to facilitate discussion of this subject. We believe there is confusion regarding the definition of physician extenders which stems in part from the lack of a generally accepted terminology. While we understand the intent of the language provided in Section (aa) (3) of S. 708, we could recommend use of the term "nonphysician primary health care provider" as a generic substitute for "physician extender." This terminology is, in our view, more appropriate and more industrial in describing the bread enterprint of health care providerical. more inclusive in describing the broad category of health care professionals who may be utilized in rural health clinics, inasmuch as some of them, for example, are nurse practitioners or physician assistants, who might not come under the definition of physician extender.

NEED FOR REIMBURSEMENT MODIFICATIONS

In some rural areas, clinics have been established to provide certain primary care and first aid services to patients who otherwise have no immediate access to such services. These clinics are operated frequently without the benefit of a physician on site to supervise the services of the nonphysician providers. Evidence of the problem to which your bill is addressed was pointed out in September 1976, in a joint statement of the Southern Governors' Conference and the Appalachian Regional Commission pointing out that 25 to 30 percent of the visits to 87 rural health clinics in that area were not reimbursed by

Medicare due to lack of direct physician supervision.

It is, of course, the intent of S. 708 to revise the reimbursement provisions of the Medicare program with respect to the payment for services rendered in these settings. However, if reimbursement revision or amendment is to be most effective, the methods and conditions of payment must be consistent with Medicare principles. In all cases we strongly recommend that payment for services provided by rural clinics be provided as defined in section 1861(v) (1) (A) of the Social Security Act on the basis of reasonable costs related to providing such services. We would oppose the provision of section (i) in S. 708 permitting payment "on behalf of an individual, on the basis of costs reasonably related to providing such services or on the basis of such other tests of reasonableness as the Secretary may find appropriate." We believe that the Secretary of HEW should not have the authority to approve alternative systems of reimbursement if such systems depart from this important principle in the oxiding Medicara program. principle in the existing Medicare program.

In view of the fact that nonphysician health care providers render services in some rural areas which lack other health resources and that there exists a problem of reimbursement in these situations, we support S. 708. Nevertheless, we are concerned about the lack of adequate physician supervision in these settings, and would recommend that reimbursement of nonphysician primary health care provider services be permitted only so long as sufficient physician direction—which would otherwise permit payment under existing provisions of the Medicare program—remains unavailable. Further, we believe that the provisions of S. 708 should be considered experimental and that an evaluation of the quality of services provided within its requirements be conducted within one year after the date of enactment to ensure that this amendment to the

Medicare statute serves its intended purpose.

We would now like to summarize our specific recommendations which we

believe will improve the provisions of S. 708.

1. The term "nonphysician primary health care provider" should be substituted for "physician extender" in the proposed section 1861(aa)(3) of the bill:

2. To assure that "nonphysician primary health care providers" meet necessary training and experience qualifications, they should be restricted in the proposed section 1861(aa)(3) to individuals who: (a) are licensed by the state in which they provide services or are in compliance with state regulatory requirements that define the limits of their practice; and (b) hold credentials from a nationally recognized organization, such as the National Commission on Certification of Physicians' Assistants, the American Nurses' Association, or the National Association of Pediatric Nurse Practitioners:

3. To be consistent with payment principles of the Medicare program, payments for services under S. 708 should be provided on the basis of reasonable costs related to providing such services, as defined in section 1861(v)(1)(A)

of the Social Security Act;

4. Nonphysician primary health care providers in hospital-based or operated clinics must be subject to the rules, regulations, and procedures of the institution with respect to the scope of services provided by such individuals; and

5. An evaluation of the quality of services as provided under the requirements of S. 708 should be conducted within one year of enactment of the bill into law.

Mr. Chairman, we appreciate this opportunity to express our views and recommendations on S. 708 for your Subcommittee, and we will be pleased to provide you and your staff with draft language to implement these recommendations at a time and in a manner which you deem appropriate.

STATEMENT OF FRED E. MONDRAGON, REGIONAL ADMINISTRATOR, PRESBYTERIAN HOSPITAL CENTER, ALBUQUERQUE, N. MEX.

Mr. Chairman, I will now present a few remarks based on my experience as Regional Administrator for Presbyterian Hospital Center, responsible for rural hospitals and clinics. My comments will also reflect my observations of rural New Mexico health care as president of the New Mexico Hospital Association and a member of the New Mexico State House of Representatives.

Rural New Mexico has one of the lowest physician to population ratios in the country. Excluding the metropolitan area of the state (Albuquerque), the ratio is 1 to 1,400, with the few physicians located in severely underserved areas being mostly older general or family practitioners.

The following is a chart which depicts the worst counties in New Mexico

in terms of population to physician ratios. They range from 1600 in Torrance County to no physicians at all in Harding County.

SEVERELY UNDERSERVED COUNTIES IN NEW MEXICO

County	Population	Number of physicians	Population to physician
Catron	2, 300	1	2, 300
Guadalupe	2, 300 4, 900	3.	1, 633
farding	1, 200	0	
tildalgo	5, 700	3	1,900
una	14, 500	5	2,900
Nora	4, 900	1	4, 900 1, 900
)uav	11, 400	6 .	1, 900
Roosevelt	16, 300	9	1, 811
Sandoval	22, 600	И	2, 055 1, 600
orrance	6, 400 4, 900 9, 800	4	1,600
Jnion	4, 900	3	1, 633
ocorro	9, 800	4.	2, 450
/alencia	46, 000	22	2, 091

To address the need, there have developed several rural clinic networks and many community-based and operated clinics which, although normally initiated through Federal or other grant support, are struggling for survival. Extensive conversations with directors of a number of rural clinics indicate that most of them would be closer to financial stability (break-even) if they could receive payment for physician extenders. Since rural areas have a higher per cent of the population in the Medicare age category than the general population, and since older patients use medical facilities to a greater extent, it is felt that the potential impact of your proposed legislation would increase clinic reimbursement by fifteen to twenty-five per cent. Thus, survival of these rural clinics comes closer to reality.

It goes without saying that older rural patients have more transportation problems, and therefore are denied access to medical care where physician extender rural clinics are the only providers available. These rural elderly patients, paying the monthly Medicare Part B fee are disenfranchised from medical care for which they are paying. The postponement of needed care, furthermore, tends to aggravate controllable diseases and leads to increases

in total costs of crisis health care.

It is paradoxical that Medicare reimbursement is not always provided for rural physician extender services in light of the stated goals of the Rural Health Initiative program, the HURA Program, and Public Law 93-641 to expand the use of physician extenders.

Addressing Senate Bill 708 itself, we concur with the standards for rural health clinics as defined. Provisions for medical review, standing orders, consultation, clinical records, transfer procedures, management policies, drug dispensing, and utilization review are appropriate factors to be addressed, by statute and regulation. Hopefully, however, the regulations for rural clinics would not be as restrictive as some Medicare certification regulations are proving to be for our rural hospitals. The State Federal Programs certifying agency would be the appropriate vehicle for certifying rural clinics.

Just as we are concerned about the regulatory red tape in the certification of Rural Health Clinics, we are concerned about the regulations and requirements which will be developed to address the issue of payment for physician

extender services.

You should see the volume and complexity of information we must provide the Medicare program for reimbursement to rural hospitals. These rural health clinics in most instances will have very little expertise in accounting, and will just be unable to meet demands for a broad range of fiscal data.

I urge the committee to insure that some simple system is evolved like a per visit payment. A simple billing procedure like this can be developed without requiring that a rural clinic hire an army of accountants to prepare cost reports. In addition, with the difficulty these clinics have in becoming economically self supporting any retroactive settlements could be devastating to

the cash flow.

Regarding the definition of physician extenders, the required certification appears to be somewhat restrictive. It is our understanding that only 700 nurse practitioners have taken the national certification examination. This represents probably less than twenty per cent of the nurse practitioners in the country. Most states have developed certification of nurse practitioners and physician assistants through Nursing Boards, Medical Practice Boards, or combinations thereof. We would hope that if such local examinations are determined by the Secretary of HEW to be equivalent to the national certification examination that they be accepted by Medicare in place of national certification.

In summary, Mr. Chairman, we strongly support Senate Bill 708 essentially in its present form and only urge flexibility in reimbursement methods and

certification of physician extenders.

Thank you for the opportunity to testify in support of this Bill.

STATEMENT OF EDGAR T. BEDDINGFIELD, JR., M.D., CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION

I am Edgar T. Beddingfield, Jr., M.D., a physician in family practice at Wilson, North Carolina. I serve as Chairman of the Council on Legislation of the American Medical Association. Appearing with me today is Harry N.

Peterson, Director of our Department of Legislation.

We are pleased to appear on behalf of the American Medical Association to express its views on a subject which has long occupied activities of the AMA—that of services provided by a physician's assistant. Although we do have concerns over the particular legislation before the subcommittee—S. 708—we hope that the hearing today will serve as a focal point, or a catalyst, for continuing discussion of the issue.

The AMA has been at the forefront in supporting the utilization of physicians' assistants and early recognized their special utility in medical care shortage areas, including rural areas. In the past we have pointed out the need to support salutary legislation recognizing the role of the physician's assistant

in serving to "extend" the services of a physician into shortage areas.

To this end we support legislation under which Medicare would recognize reimbursement to the physician for services performed by him through his supervised assistant and would recognize reimbursement whether the assistant performs services at or away from the physician's office. We believe that this would encourage wider use of the assistant and give proper recognition to the essential nature of the assistant, which is to extend the physician's services. Such provision of service can be of proper quality when the assistant has received sufficient formal training from appropriately accredited training programs, meets any State requirements for provision of services, and remains subject to, and answerable to, the supervision of a physician. The latter qualification makes clear the proper, critically essential role of the supervising physician, which is to assure that his assistant is properly trained and supervised and that the physician responsible for the assistant's actions must remain answerable to, and take responsibility for the proper treatment of, the patient. Failure to retain such a relationship would be detrimental to quality patient care in the long run.

While an assistant can be especially advantageous in shortage areas in which no physician is located, caution must be taken to assure that the care provided by the assistant is quality care. In a rush to provide some care to

an area which may otherwise have little or no care it would be easy to brush aside proper safeguards. We must preserve for all patients—including those in rural areas—a high standard of care.

The bill before you—S. 708—does address certain of our overall considerations.

EXTENDER REQUIREMENTS

The bill defines the "physician extender," as a "physician assistant, nurse practitioner, nurse clinician, or other trained practitioner who is certified as a physician's assistant by the National Commission on Certification of Physician's Assistants or its successor, or who is certified as an adult-family nurse practitioner by the American Nursing Association of its successor, and who is legally authorized to provide any physician services, as defined in section 1861(q), in the jurisdiction in which such services are provided."

A requirement that the extender meet State requirements is a provision which we have supported, and we believe that such a provision properly recognizes the primary (and exclusive) power of the individual State to determine the qualifications and scope of practice of an extender. However, the definitions in S. 708 create ambiguities. Under one interpretation the definition of extender would be met only when the extender was authorized to perform any physician services, meaning all the services which a physician could perform. This broad requirement would in effect exclude intended coverage. On the other hand it may be met if the extender could perform any, meaning just one such physician service. Moreover, the reference to the local jurisdiction does not in any way circumscribe eligible services, but serves merely to identify the extender. In addition, as discussed below, the definition of "rural health clinic services" is very broad, the only limitation being the services "performed by an extender." Thus the effect from the language may be an unintended broad scope of coverage beyond services recognized in the local jurisdiction. We do not recognize that one later provision states that the bill should not supersede state law.

In addition, we question the advisability in the definition of a physician extender of the provision that such an individual be legally authorized to provide "any physician services, as defined in section 1861(q)" of the Social Security Act. The term "physicians' services" under Title XVIII of the Act means "professional services performed by physicians. . . ." It would further appear that to require a physician extender to be authorized under State law to provide physicians' services as that term is used under the Social Security Act may well conflict with a state's requirement that only physicians may

practice medicine.

We believe the bill could overcome these concerns with the definitions by clearly stating that services of a physician extender would be recognized only to the extent that he is legally authorized to perform such services in the

jurisdiction in which such services are provided.

We are also concerned that the bill specifies certain "accrediting" agencies for educational qualifications of extenders. We believe that it is more appropriate, in an area traditionally within the purview of the state, for the state to establish eligibility requirements for providing health services.

As we have indicated, the term "rural health clinic services" raises a particular problem. There does not appear to be sufficient limitation on what may constitute a rural health clinic service, since a requirement is only that such

services be furnished by a physician extender.

The term "rural health clinic services" also makes reference to the term "primary care patient". The scope of medical care encompassed in the term "primary care" has not been universally defined, and accordingly the term would introduce many problems relating to coverage and eligibility.

RURAL HEALTH CLINICS

Certain portions of S. 708 recognize concepts on which an extender program should be built. However, other portions of the bill are troublesome. While the objective, ostensibly, is to provide payment for services of the physician extender, the bill in fact would add a new payment authorization for "rural health clinic services." Thus, after defining a physician extender and rural health clinic services, the bill then goes to great length to set up a new exclusive type of entity under Medicare Part B for purposes of reimbursement. Reimbursable services under the bill (principally those of the extender) would be those services provided only by a "rural health clinic," would be reimbursed only to the "clinic", and would be reimbursed on the basis of "costs reasonably

related to providing such services or on the basis of such other tests of reasonableness as the Secretary may find appropriate."

The "rural health clinic" itself would be defined as "a facility" which complies with all of the following: (1) provides rural health clinic services, (2) has an arrangement with a physician for review of all services provided by the physician extender, (3) provides for the preparation by the supervising physicians and physician extenders of medical orders for care and treatment of clinic patients, (4) provides for the availability of the supervising physicians for such referral and consultation for patients as is necessary, (5) maintains clinical records, (6) arranges for referral and admission to hospitals, (7) has written policies to govern the management of the clinic and all the services it provides, (8) has appropriate procedures and arrangements in compliance with state and federal laws concerning drugs and biologicals, and (9) has appropriate procedures for utilization review.

As a further limitation, such a clinic could only be one which is "not located in an urbanized area (as defined by the Bureau of the Census) where the supply of medical services is not sufficient to meet the needs of individuals residing therein. . . ." This language is somewhat confusing since the clause "where the supply of medical services is not sufficient to meet the needs of individuals residing therein" could be read to apply to the nonurbanized area

or to the urbanized area.

The bill would reimburse only the new type of "clinic" for services of an extender plus those services which are "incident" to a physician's services.

A glaring inconsistency is created by the provision limiting payment to a "clinic." By what reasoning should a facility be the exclusive entity reimbursed for what must be identified essentially as physician's services? The fundamental concept is that the extender is providing an extension of "physician" services. The physician character of the services furnished by the clinic is further emphasized since the bill would only recognize, in addition, services "incident to a physician's professional service." We believe that the provisions of the bill in this regard strain logical analysis, in attempting to have Medicare pay a specially recognized facility—the rural health clinic for physician services performed by a non-physician.

While a physician directed and operated clinic is not specifically excluded under the language, we find it difficult to conceive of a situation in which a physician would operate a "rural health clinic." In fact disincentives for participation by physicians are contained in the bill. If he did operate such a clinic, he would be reimbursed for extender services on the basis of "cost" as determined by the Secretary. Moreover, physicians would be reluctant to allow the extender to participate in preparing "medical orders" for patients. We

believe the bill discourages physician operated "rural health clinics."

In addition, the bill does nothing to encourage physicians to comply or to make greater use of physician extenders outside of the so-called "clinic" setting. If in fact it would turn present satellite settings into "clinics", the bill

could well be directly counterproductive.

The disincentives are compounded when read in conjunction with the requirement of the bill that such "clinics" be subject to capital expenditure review under section 1122 of the Social Security Act. A physician's office is not, nor should it be, subject to such review. However, if under the bill a physician's office or his satellite office will be interpreted to come under such a review, this would surely discourage physicians from participation.

More importantly, however, is the failure of the bill to allow reimbursement for extenders employed directly by physicians outside any "clinic" setting. We believe that this failure, by creating a distinct bias in allowing reimbursement only to a "clinic", will hinder the expanded use of the physician extender.

Another ambiguity relating to the concept of a rural health clinic concerns the organizational makeup of such a clinic, i.e., the "facility" as an entity recognizable for receipt of payment. To what entity or person would payment be made?

RESPONSIBILITY FOR EXTENDER

As we pointed out earlier in our statement, we have long supported the use of the physician assistant. However, we believe that this person should be utilized as originally intended, i.e., as an extension of and assistant to the physician with the physician remaining *primary responsible* for the assistant's patient care functions. We believe that actions of the extender should be viewed as the extension of the physician and therefore the physician should retain sole supervision of the extender.

As the bill is written, however, it is unclear exactly who is responsible for the actions of the extender. Although in the definition of the clinic there is a requirement for a review of the extender's services by a physician, the definition also "provides for the preparation by the supervising physicians and physician extenders of medical orders for care and treatment of clinic pa

tients." (Emphasis added.)

We must question the language in this provision which might be interpreted as sanctioning the preparation of medical orders by the physician extender. This language of the bill does not assure sufficient supervision of medical services provided by an extender and could well lead to Medicare reimbursement for services which would not be reimbursable under other circumstances.

PAYMENT INCONSISTENCY

Because payment under this bill is limited to the clinic, the extender's services would be paid in the clinic setting but payment would continue to be

denied when services are furnished in another setting.

For example, under present HEW interpretations, the only way in which the extender's services could be reimbursed now would be if they were performed "incident to" a physician's professional service. Furthermore, under HEW interpretation this ". . . limits coverage to the services of nurses and other assistants that are commonly furnished as a necessary adjunct to the physician's personal in-office service. Thus, the performance by a physician's assistant of services which traditionally have been reserved to physicians cannot be covered under Part B even though all the other 'incident-to' requirements are met."

Now, however, S. 708 proposes to reimburse a clinic the costs for extender services, but would not allow reimbursement directly to the physician if such services are not "incident to" a physician's services. Yet, as we have pointed out, under present Medicare practice, services recognized as "incident to" physicians' services would not include many extender services when performed under the direction of a physician while those same services would be recognized under the bill where the extender is essentially unsupervised. We believe that services of an extender should be reimbursed, but we do not understand the rationale for allowing such reimbursement to a facility for services performed while those same services would not be reimbursable when performed under the direction or supervision of a physician such as in his own office.

The bill also creates a further inequity among beneficiaries because payment for "clinic" services would be made under Part B without being subject to the Medicare deductible. At present, payment of benefits under the Medicare program is subject to a deductible of \$60 during a calendar year. Not requiring such a deductible for services received by a patient in a rural health care clinic would appear to be discriminatory, not only with respect to the type of service involved, but also as to other Medicare beneficiaries.

We believe that the bill as presently written in its attempt to reach a laudable end could create many unintended problems which could adversely

affect development of quality care.

AMA ACTIVITIES

The AMA is not unmindful of the needs of shortage areas. We have long advocated increased medical manpower for shortage areas and to that end have strongly supported programs under the manpower law, including the National Health Service Corps program. We have also developed and have had introduced our own bill on Rural Health Care.

We have also long carried out the Project U.S.A. program, designed to fill temporary vacancies for National Health Service Corps personnel temporarily

absent for vacations or leaves.

In addition we have also encouraged the development of rural health care delivery models with utilization of physician extenders to increase the scope of services and with the use of satellite arrangements in sparsely populated areas. Our annual National Conferences on Rural Health and our Extension Seminars on Health Education as well as our publications in the rural health field prepared for public distribution also attest to our support for such developments.

However, while the AMA has provided a leadership role in rural health, we have always adhered to the principle of rural health care equal in quality to

that of the rest of the nation.

As to the physician's assistant, we have also long advocated recognition of their services as part of physicians' services under Medicare irrespective of where the extender actually performs the service and irrespective of the physical presence of the supervising physician. We support demonstration projects designed to study the utilization of the physician assistant. The subcommittee is undoubtedly aware of the reimbursement studies now being undertaken by HEW.

CONCLUSION

Mr. Chairman, we are indeed sympathetic with the problem which the Committee has before it, and we recognize the desirable objective of the legislation. The bill emphasizes the difficulties which arise when the Medicare program is sought to be used and tailored to reach what is perceived to be very limited and special situations. However, once a payment system is provided and an entity created and recognized for payment purposes, proliferation will certainly follow, so it is important that proper medical safeguards be provided. While we recognize also the exigencies that pertain to certain rural situations, we must be careful to avoid a duplication of problems, as recently came to light concerning quality and propriety of services in the so-called Medicaid Mills, generally identified with urban areas.

We have already pointed out the bill creates some anomalies. If the Medicare program is to recognize payment for services of physician extenders, discrimination should not be created against the fundamental situation out of which the physician extender movement developed. The basic concepts must include (1) proper supervision and control by the physician of a properly trained physician extender, (2) responsibility in the physician for the services as evidenced by the billing for the services in the name of the physician, and (3) compliance with state requirements. If these are adhered to, the use of physician assistants would be encouraged in shortage areas. To this end, a simple amendment to the Medicare law giving recognition to the true nature of the extender's service would be more appropriate than creating the Medicare-defined "rural health clinic" in order to recognize the extender's service. Accordingly, a simple amendment to include the extender's service as an integral part of the physician's service would foster the development of the original concept and help provide quality care in rural areas.

S. 708 as presently written should not be adopted.

Mr. Chairman, we will be pleased to respond to any questions which the Subcommittee may have.

STATEMENT OF ANNE ZIMMERMAN, PRESIDENT, AMERICAN NURSES' ASSOCIATION

I am Anne Zimmerman, President of the American Nurses' Association. I request that, in addition to my remarks as a participant in the panel which you have arranged, the following statement be included in the record of this

Thank you for the opportunity to present the views of the American Nurses' Association on the matter before you, S. 708 a bill to amend title XVIII of the Social Security Act to provide payment for rural health clinic services. We see this legislation as a significant step towards a national health policy calling for comprehensive health care services that are affordable, available

around the clock, and readily accessible to all who need them.

The findings of your subcommittee's field hearings last year are correct. The provisions within the Medicare reimbursement program are restrictive and prevent the delivery of needed health care services to persons who reside in rural areas in this country.

We strongly support the move for change in Medicare reimbursement policies and the general approach which the subcommittee is taking in seeking to deal

with this problem.

However, we recommend certain changes in S. 708—changes which would remove remaining roadblocks to the delivery of health care services in rural areas and would be a thoughtful response to the real health care needs of the people who live in these areas.

Before discussing the concerns of the American Nurses' Association with S. 708, I would like to discuss the needs of rural Americans for health care

services.

Data concerning the actual health problems of the rural population are not easily compiled because they have been a neglected part of data collection systems. However, if the needs of people in rural areas are similar to those of the nation as a whole, then data compiled by the National Center for Health Statistics in the National Ambulatory Medical Survey in 1973-74 might be of some help.

This survey gathered data from the offices of office-based physicians from May 1973 to April 1974. There were an estimated 644.9 million visits or encounters, and 15.5% of all visits were by patients 65 years of age and

over. (100,249,000 visits.) 1

The majority of "patient complaints" for this age group were high blood pressure, vertigo/dizziness, fatigue, vision dysfunction, chest pain, leg pain, stomach pain, etc. According to the classification for this age group in the International Classification of Diseases, Adapted, the actual diagnosis of these patients' problems were, in rank order: chronic heart disease, diseases of the circulatory system, diabetes, diseases/conditions of the eye, neoplasms, etc.

The diagnosis, treatment and management of these older Americans' health problems are paid for mostly from public funds. In the June 1976 Social Security Bulletin, it was reported that, "Most of the elderly receive a major portion of their health care under Medicare and nearly one-fifth of them receive Medicaid benefits that supplement Medicare protection or pay the premium costs for the supplementary medical insurance part of the program. Thus the financing of health care for the aged comes primarily from public funds. A total of \$12.8 billion from Medicare and \$1.9 billion from Medicaid accounted for 89 percent of the \$19.9 billion in public spending for persons

What those people are receiving are primary health care services—services that are readily available to only a certain few groups of the population in

urban areas.

Primary health care is defined in the report of the H.E.W. Secretary's Committee to Study Extended Roles for Nurses, Extending the Scope of Nursing Practice, as having two dimensions, "a person's first contact in any given episode of illness with the health care system that leads to a decision of what must be done to help resolve his problem; and the responsibility for the continuum of care, i.e. maintenance of health, evaluation and management of symptoms, and appropriate referrals." Implied in this definition are services by professionals capable of recognizing illness, deciding what must be done, and assuming responsibility for helping clients prevent illness and maintain health. Nurses are such professionals.4

The problems with S. 708 lie in the concept of "medical" care vs. the concept of "health" care and in the roles and functions of the health care providers

mentioned in the bill.

¹ National Center for Health Statistics. The National Ambulatory Medical Care Survey,

¹ National Center for Health Statistics. The National Ambulatory Medical Care Survey, 1973 Summary, United States, May 1973-April 1974. Washington, D.C.: U.S. Department of Health, Education, and Welfare, Public Health Service.

² Social Security Administration. Social Security Bulletin, Vol. 39. No. 6, (June 1976). Washington, D.C.: U.S. Department of Health, Education, and Welfare, p. 22-23.

³ HEW Secretary's Committee to Study Extended Roles for Nurses. Extending the Scope of Nursing Practice. Washington, D.C.: U.S. Govt. Printing Office, 1971, p. 8.

⁴ American Academy of Nursing. Primary Care by Nurses: Scope of Responsibility and Accountability. Kansas City: American Nurses' Association, 1977, p. 2-4.

Although this bill to amend the Social Security Act is directed at correcting an important obstacle to the provision of certain medical services to rural Americans, it is also important to recognize that obstacles to the provision of comprehensive and needed primary health care services which can be pro-

vided by nurses have not been adequately addressed.

"Health care" is not synonymous with "medical care." While the term "medical care" emphasizes the curing of illness, the term "health care" incorporates the meaning of medical care and also emphasizes the preserving of wellness. "Health care" is a term which acknowledges the need for thought and action from a variety of health providers—an essential to all broad health decisions. It follows that adequate health care of individuals requires the collaborations of a variety of health care practitioners. Foremost among these are registered professional nurses who comprise the largest group of health care practitioners, whose primary care services are too often underutilized because of financing mechanisms.

Nurses educated for primary health care are prepared to provide prenatal, postnatal, and well-child care; guidance regarding nutrition and immunization; assistance in coping with illness and adapting to disability and old age; supervision of treatment; and physical and psychological comfort from birth to

death.

These nurses use the available information and technology to obtain baseline data about their clients and to detect change. They use research findings to improve their practice, develop nursing theory, investigate puzzling questions, and contribute to knowledge.⁵

In order for the proposed legislation S. 708 to guarantee access to such primary health care services as were identified earlier in this testimony, we sug-

gest the following changes:

1. Section 1861 [Sub-section (S) (2) (A)] as proposed be amended by striking the term "physician extender" as it appears on page 2, line 9, and inserting "primary care provider."

2. Section 1861 (S) (2) (B) as proposed be amended by striking the term "physician extender" as it appears on page 2, line 19, and inserting the phrase

"primary care providers as this term is defined in this act."

3. Section 1861 (S) (2) (C) as proposed be amended by striking the term "supervising" as it appears on page 2, lines 21-22; by striking the term "physician extenders" on page 2, line 21, and inserting the term "primary care practitioner"; striking the term "medical" in line 21 and inserting the word "medical" after the word "for" in line 22.

"medical" after the word "for" in line 22.

4. Section 1861 (S) (2) (H) as proposed be amended by striking the word "medical" as it appears on page 3, line 16, and inserting the phrase "primary health care" in its place. We request that this subsection be further amended by striking the word "medically" as it appears on page 3, lines 19 and 22.

by striking the word "medically" as it appears on page 3, lines 19 and 22.

5. We further recommend that Section 1861 (S) (2) (H) (3) be further amended by striking all of page 3, lines 23, 24 and 25, and page 4, lines 1, 2, 3, 4, 5, and 6 and inserting the following statements: "The term 'primary care provider' means, for the purposes of this subsection, a nurse practitioner, clinical nurse specialist or physician assistant who performs such services as he is legally authorized to provide primary care services as determined in Section 1861Q (in the state in which he performs such services) in accordance with state law (or state regulatory mechanisms provided by state law). In addition, nurse practitioners and clinical nurse specialists must be certified by a Division on Practice of the American Nurses' Association or its successor, and physician assistants must be certified by the National Commission on Certification of Physician's Assistants or its successor."

6. That Section 1864 (g) be amended as proposed on page 5, line 10, by striking the word "extender" and inserting the word "assistants" in its place

and by adding the phrase, "by registered professional nurses."

In my introductory remarks, I discussed the American Nurses' Association's concern about the need for specificity in regard to primary health care services. I also touched on the association's concern about the effect of the bill on the roles and functions of primary health care providers. The following rationale will provide some insight into the association's request for changes in the

⁵ American Academy of Nursing. Primary Care by Nurses: Sphere of Responsibility and Accountability. Kansas City: American Nurses' Association, 1977, p. 2-4.

language of the bill concerning those roles and functions, particularly of nurses.

Our request that the term "physician extender" be struck wherever it appears in S. 708 and the phrase "primary health care practitioner" be inserted in its place is based on well-documented distinctions in the definition and scope of practice and preparation for practice, as well as the legal basis for the practice of these health care provider. These distinctions make it inappropriate for nurses who provide primary health care to be classified as "physician extenders."

For all concerned, the terms require clarification. Physician assistants and Medex personnel are trained under the aegis of the medical educational system to supplement the physician by assuming specific tasks that consume the val-uable time of the physician, which in turn restricts his mobility and the efficient use of his special expertise. In 1970, the American Medical Association Board of Trustees published their definition of the physician assistant.

The physician assistant (P.A.) is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant.

In most states, physician assistants are not licensed. The employing physician determines the scope of practice and what is to be delegated to the physician assistant. State laws and regulations of physician assistants codify the authority of the physician to employ physician assistants.

The nurse practitioner, as defined by the American Nurses' Association Council of Family Nurse Practitioners and Clinicians, is a primary care provider prepared to give continuous, personalized care to the patient/client at the point of entry into the health care system, and to continue as the individual's care provider. The nurse practitioner is a registered nurse prepared in a degree-granting program or in a post-R.N. continuing education program.

A nurse practitioner's preparation consists of a specialized program of study beyond that required for R.N. licensure. It must meet the ANA Guidelines for Short Term Continuing Education Programs that prepare a nurse to function in an expanded role. Published guidelines include those written for pediatric, family, adult, school health, college health, and obstetric-gynecologic nurse practitioners. Programs range from 36-52 weeks in a continuing education program to programs granting baccalaureate and master's degrees.

The Divisions on Practice of the American Nurses' Association provide for certification of nurse practitioners. To date more than one thousand nurses

have entered the certification process.

A nurse practitioner (N.P.) is an independent licensed health care professional responsible and legally accountable to the consumer. The nurse practitioner is expected to make complex professional judgments on a wide range of patient care problems. These judgments can and often do mean the difference between life and death. Like other health care professionals, the nurse

practitioner must carry personal liability insurance.

Clinical nurse specialists are primarily clinicians with a high degree of knowledge, skill, and competence in a specialized area of nursing. The services of clinical nurse specialists are made directly available to the public through the provision of nursing care to clients and indirectly available through guidance and planning of care with other nursing personnel. Clinical nurse specialists hold master's degrees in nursing, preferably with an emphasis on clinical nursing.

We believe it is unnecessary for the bill to make reference to "supervisory physician" as it applies to nurses. Integral differences between nurse practitioners and physician assistants, by definition, preparation and legal status

as already described, are the basis for the second proposed change.

We must emphasize that the nurse practitioner is licensed as an independent health professional. The law does not place nurses under the supervision of any other profession. To make this a requirement in this legislation would be restrictive and clearly supercedes the provisions of state laws governing the practice of nursing.

In deliberating about the provisions included in this bill, we took the op-

portunity to explore how Title XVIII defines "supervision."

"Supervision" is not defined in Title XVIII itself, but the regulations do define it in the context of the specific areas in which nursing services are reimbursable.

With respect to inpatient hospital care, the regulations require that, for reimbursement of nursing services, certain conditions be met. The regulations require that there be well-established working relationships between nurses and other health professionals. Registered nurses are expected to "confer with the physicians relative to patient care." Interdepartmental policies affecting nursing service and nursing care must be made jointly with the director of nursing. Nursing services are planned, reviewed and evaluated by a registered professional nurse. In accordance with the nurse practice act of the particular state, nurses are permitted to give medication without any supervision. [Title 20 CFR Sec. 405.1024 (f), (g).]

With respect to outpatient services, a physician is responsible for "the professional services of the department," but the next sentence reads: "A registered professional nurse is responsible for the nursing services of the depart-

ment." [20 CFR Sec. 405.1032 (b) (1) and (2).]

With respect to emergency services, all patients must be seen by a physician, but qualified nurses must be constantly available. Nothing about supevision is

mentioned. [20 CFR Sec. 405.1038 (d).]

With respect to psychiatric hospitals, nursing services are under the direct supervision of a registered professional nurse with appropriate training and/

or experience. [20 CFR Sec. 405.1038 (d).]

With respect to skilled nursing facilities, nursing services are supervised by a registered professional nurse. Nurses are permitted to dispense drugs in accordance with written orders of the attending physician. [20 CFR Sec. 405.1124 (a), (g) and (b).]

With respect to home health, nursing services are by or under the supervision of a registered professional nurse. The home health nurse is expected to coordinate services and to inform the physician and other personnel of

changes in the patient's condition. [20 CFR Sec. 405.1224 (a).]

The common meaning of "supervise" is to superintend, which means to have charge and direction of; to direct course and oversee details; to regulate with authority; to manage; to have or exercise the charge and oversight of; to oversee with power of direction; to take care of with authority.

The word "supervise" definitely relates to acts of others rather than to those of the person doing the supervising. To supervise does not mean to do the work in detail but to see that it is done. It means to oversee with power

of direction. [Egner v. States Realty Co., 26 NW 2d 464.]

The word "supervise" means to be able to direct, to oversee and to exercise authority and [supervision] is a quality which requires more than mere legal authority and connotes not only knowledge but executive capacity. [Rosenstranch v. Reany 21 NYS 2d 358.]

"Consult" means to seek opinion or advice of another; to take counsel; to deliberate together; to confer; to deliberate on; to discuss; to take counsel to bring about; devise; contrive; to ask advice of; to seek the information of; to apply to for information or instruction; to refer to [Teplitsky v. City

of New York 133 NYS 2d 260,261.]

Reinhardt, an economist at Princeton University, supports this point of view. He states: "If (nurse practitioners) must remain under visual supervision (or authorization) of a physician, their special and specialty distribution will necessarily parallel those of a physician, and thus permit continued existence of gaps in access to primary care.'

In current practice, in most instances, the physician's signature for Medicare authorization for reimbursement is only that—a signature. For most patients (generally 80-90% of their practice), the nurse practitioner sees, as-

sesses and treats with no direct physician involvement.

It is important to clarify that ANA is advocating physician involvement in the delivery of primary health care by nurse practitioners. We recognize the critical necessity of appropriately delivered medical care by a physician. There

is much care only a physician can deliver.

If a nurse practitioner is to provide quality care, it is imperative that a colleague relationship be developed with a physician. Where there is overlap in services between the physician and the nurse practitioner, a mutually agreed-upon framework must be developed for the provision of joint care.

We not only support collaboration, consultation and referral between nurse practitioners and physicians but recognize the absolute necessity of this relationship if comprehensive health care is to be provided. Nurse practitioners

are ethically, legally and morally committed to the right of consumers to adequate services. The physician is the recognized expert in medical aspects of health care, the nurse in nursing aspects. The roles of each are complementary and not substitutive.

Nurse practitioners deliver care in a variety of settings including but not limited to homes, ambulatory care centers, health maintenance organizations, schools, industries, and physician's offices. Statistics indicate that a large number of nurse practitioners are in rural states and the majority practice

in clinics providing direct primary care.

The nurse practitioner delivers health care which includes not only physical assessment, but also assessment of the emotional and developmental status of an individual and the family, as well as an analysis of health behavior. Practicing nurse practitioners have a collaborative arrangement with a physician. A collaborative arrangement indicates a cooperation in the management of a patient's health care problem, when necessary. A nurse practitioner functions "interdependently" and has a physician available for ready consultation and to whom a patient can be referred. Such physician services, whether on site or by telephone or other means, must, of course, be reimbursable under all third party payment plans. In this way, the client benefits from both the nursing perspective and the medical perspective.

The nurse role and the physician role are not merely greater and lesser degrees of a single role, but are coordinate and complementary in providing high quality primary health care. Each role constitutes a different emphasis of practice. The nurses' emphasis is on the psychosocial needs of patients rather than just the pathological; the emphasis is on preserving wellness, not just curing illness; the emphasis is on the whole patient and on coordinating

total health care rather than giving just isolated bits of care.

The scope of primary nursing practice includes: Assessment of the physical, emotional, and developmental status of the individual and family; assessment of the environmental status of the community and its impact on health; analysis of health behavior related to personality, life style, and culture; provision of primary care through diagnosis, clinical judgment, and management to restore, maintain, and improve health status; teaching, counseling, and serving as an advocate; collaboration and/or coordination with other health care providers and community organizations; initiation and/or participation in clinical nursing research and in the application of research findings to practice.

We must reiterate that in most states physician assistants and Medex personnel function under a licensed physician. It is understood that the physician assistant and Medex personnel function under the professional and legal supervision of the physician. Therefore, the physician is ultimately responsible

for the care.

In contrast, a nurse is licensed and registered by a state. The law does not place the registered nurse under the direct supervision of any other health discipline. As mentioned earlier, nurse practitioners carry their own malpractice insurance and assume full legal accountability for their individual nursing acts. Their authority to practice resides in the nurse practice act in each state, and the Board of Nursing is responsible for regulating nursing practices.

About twenty nurse practice acts have some arrangement for participation of the medical profession in the establishment of rules and regulations to govern their practice. This is evidence of recognition by both professions that these areas of practice are common to both the practice of nursing and medicine

We respectfully request that the law you are proposing is explicit that the service provided by nursing in rural clinics is *not* that of a second rate physician where second rate is better than none, but that, within this shared area of practice, nurses have the same competence as any other professional

who has traditionally operated in that area.

In summary, the American Nurses' Association would support S. 708 only with the changes recommended herein. To do less would be a denial of the known needs of Medicare beneficiaries for primary health care services, most of which can be provided by qualified registered professional nurses. If people are to have access to such services, nurses must be recognized as providers of health care whose services are reimbursed through health insurance provisions of the Social Security Act.

STATEMENT OF DAN FOX, PRESIDENT-ELECT, AMERICAN ACADEMY OF PHYSICIANS' ASSISTANTS, ARLINGTON, VA.

Mr. Chairman and members of the committee: I am Dan P. Fox, President-Elect of the American Academy of Physicians' Assistants. I am here today to offer testimony regarding Medicare reimbursement for services rendered by physician assistants. I wish to thank the Committee for the opportunity to present the views of the practicing physician assistant profession on this important piece of legislation.

The American Academy of Physicians' Assistants shares with the Congress its concern over the ever-increasing cost of delivering health services to the people of this nation. We are equally concerned about and committed to the provision of primary health services that are easily accessible to the aged and

medically deprived populations in our rural towns and urban centers.

The Academy believes that the utilization of physician assistants by qualified physicians can help slow the spiraling cost of medical care, while extending the access of care to more people than ever before. In fact, our literature is replete with articles testifying to the benefits of PA utilization in various parts of the country. However, one major stumbling block still exists that is delaying the optimum utilization of physician assistants, and that is the lack of federal reimbursement to physicians for services rendered by physician assistants.

BRIEF INTRODUCTION TO THE PROFESSION

Since the development of the first physician assistant program in 1965, "educational essentials" in primary care, surgery, and urology have been developed by the American Medical Association in conjunction with medical specialty societies including the American Academy of Family Physicians, the American College of Surgeons, and the American Urological Association. The American Medical Association (AMA) defined the physician assistant as "... a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant." The U.S. Office of Education has recognized the AMA accreditation mechanism and, to date, more than fifty (50) PA programs are accredited.

Professional associations were formed including the American Academy of Physicians' Assistants (Academy), incorporated in 1968, followed by the Association of Physician Assistant Programs. These associations have assumed an influential position in defining the roles of physician assistants in the field of medicine so as to maximize the hopefit of their corporates to the public

medicine so as to maximize the benefit of their services to the public.

In response to the need for a national measure of competency, the National

In response to the need for a national measure of competency, the National Board of Medical Examiners (NBME) accepted responsibility in April 1972 for developing a national certifying examination for assistants to the primary care physician. Following the administration of the first examination by the NBME in December, 1973, fourteen (14) collaborating organizations formed the National Commission on Certification of Physician's Assistants (NCCPA). The National Commission is comprised of individuals from the following organizations: American Academy of Family Physicians, American Academy of Pediatrics, American Academy of Physicians' Assistants, American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, American Nurses Association, American Society of Internal Medical, Association of Physician Assistant Programs, Federation of State Medical Boards of the United States, National Board of Medical Examiners, and the United States Department of Defense. In order to maintain the high standards of the physician assistant profession, a reregistration and recertification process has been established by the National Commission.

State legislatures and regulator agencies have assumed responsibility in recognizing the physician assistant and in regulating their practice. Over 40 states have enacted enabling legislation for physician assistants and, to date,

no PA has been convicted of professional negligence.

American medicine has therefore seen the establishment of a new profession with ongoing program accreditation, graduate certification, and the establishment of professional associations intent on maintaining the high standards of the profession.

BENEFITS DERIVED THROUGH THE USE OF PHYSICIAN ASSISTANTS

Having practiced for two years in a rural family medicine practice in Indiana, I can attest to the role of the PA in such a setting. In fact, the results of my practice experience were published in the Journal of the Indiana State Medical Association in July, 1972 by my former employer, Dr. Dan Hibner. In that article, he stated that "we find patients are seen sooner in the course of their illness, resulting in a lowering of the costs to the patient by reducing the need for expensive hospitalization or further diagnostic tests." This increased accessibility and emphasis on preventative medicine, with its resulting cost-savings to the patient, is one of the major benefits brought to the practice by the PA.

Other benefits that can be derived from the education and utilization of

physician assistants are:

(1) Physician assistants can be educated in a relatively short period of time (2 years as compared to 8 to 13 years for the physician) which can reduce the overall costs of medical education and increase the availability of primary health care services at a faster rate.

(2) Physician assistants can help solve the physician manpower maldistribution problem by expanding the available physicians' delivery of health

services.

(3) By assisting in the evaluation of the worried-well and asymptomatic patient, who consumes an enormous amount of a physician's time, and by relieving the physician of the burden of a number of routine duties, the physician can reallocate his time and energies to treating those patients who require the expertise of a physician. In addition, the time savings would allow the physician to keep more abreast of new developments in medicine, help prevent work overload and resulting fatigue, and increase the physician's professional life span of service to the community.

(4) By helping to increase the time-savings to the physician and decrease the amount of fatigue experienced by overworked physicians, the physician assistant can reduce the potential for negligence to occur in the treatment of

patients, thereby providing a better quality of services rendered.

The Congress, recognizing these potential benefits, has enacted two significant pieces of legislation: the Comprehensive Health Manpower Training Act of 1971 and the Health Professions Educational Assistance Act of 1976 funding the training and deployment of physician assistants. This funding has increased the number of education programs preparing PAs, from six in 1965, to over 50 in 1977. However, these monies and the hope for increased health services may have been in vain if the over-riding problem of reimbursement is not solved soon.

BARRIER TO EFFECTIVE UTILIZATION

Just as every American has the right to accessible quality health care, so do physicians deserve reasonable reimbursement for patient care services rendered by physician assistants. Title XVIII of the Social Security Act does not adequately authorize Medicare Part B reimbursement for physician assistant services. (Section 1861 (s) (2) (A)/of Title XVIII of the Social Security Act.) Thus, the performance by a physician assistant of services which traditionally have been reserved to physicians cannot be covered under Medicare Part B even though all other "incident-to" requirements are met. Until Title XVIII of the Social Security Act is amended by Congress to provide Medicare (Part B) coverage for physician assistant services, the PA profession will not reach its recognized potential, and the consumer may not realize the right to accessible health care.

Under authorization from H.R. 1 (P.L. 92–603, Section 222), the Social Security Administration has been given responsibility for the implementation of a research study evaluating physician assistant reimbursement. The objectives of the reimbursement study are admirable, but unfortunately, the final outcomes from this study will not be available and reported until 1978. Without immediate legislated medicare reimbursement, there exists the potential for decreased graduate demand and the possibility that PAs may be forced to practice within institutional settings where reimbursement by specific formu-

las may be obtained under Medicare Part A.

The reimbursement situation is complex. Physicians deserve reasonable reimbursement for physician assistants rendering patient care under their em-

ployment, and at the same time, there is a need to institute containment of health care costs. It must be appreciated, with physician assistants, there would not be a free-for-service relationship between them and the Medicare beneficiary. It seems reasonable to assume that there would be no increase in cost to the Medicare programs, except as unmet needs of Medicare beneficiary.

ficiaries are achieved.

The American Academy of Physicians' Assistants, in discussing and debating the development and endorsement of an appropriate reimbursement mechanism, has identified three methods for reimbursement of physician assistant services. First, there are those who would favor "discriminating" increased reimbursement providing physicians who practice in medically underserved areas, as identified by the Secretary (DHEW), with Medicare Part B reimbursement at greater than one-hundred percent (100%) of reasonable and customary rates of reimbursement. Secondly, there are proponents of "discriminating" reduced rates of reimbursement. Under this system, physicians employing physician assistants in medically underserved areas would be reimbursed by Medicare B at 10% of reasonable and customary rates of reimbursement, all other physicians employing physician assistants would be reimbursed for patient care services rendered at less than 100%. Thirdly, there are those who would support reimbursement for the patient care services rendered by all PAs at 100% of reasonable and customary rates of reimbursement irregardless of practice location.

Economic incentives rather than economic barriers must be developed if shifts in manpower distribution and appropriate utilization are to be appreciated and the patients are to receive high quality, low cost and accessible health care. Currently, there are negative incentives for physicians practicing in rural areas, e.g., a family practitioner rendering a service in a remote rural-part of this country will be reimbursed by Medicare Part B at a lower rate than the family practitioner rendering this same service in an urban community. Therefore, physicians have been provided an incentive to specialize and to practice in an urban community where they have received higher rates

RECOMMENDATIONS

of reimbursement under the supplemental medical insurance program.

The American Academy of Physicians' Assistants commends the sponsors and the committee for introducing and considering S. 708. We believe that the cost reimbursement for rural health clinics is a necessary method of assuring the continuance of delivery of needed medical and health care services to patients near such clinics. However, we believe the legislation stops short of addressing all of the issues involved. We recommend that the committee con-

sider amending the bill to include the following:

(1) In subsection (j) add "with respect to physican assistant services (not-withstanding subsection (1)), payment shall be made to the supervising physician, on behalf of the beneficiary, at the usual and customary rates of reimbursement for those practices located in other medically underserved areas, as defined by the Secretary (DHEW), and at reasonable and appropriate rates of reimbursement, as determined by the Secretary (DHEW) for all other practice locations."

(2) In subsection (aa) (2) (b) delete the words "under which provision is made for the periodic review by such physicians of" and insert therefore "to

provide responsible supervision for."

(3) In subsection (aa)(2)(c) insert the words "responsible supervision"

between the words "such" and "referral."

(4) In subsection (aa)(3) delete all of this subsection and insert therefore "the term physician assistant means any individual who has completed an educational program for physician assistants accredited by the American Medical Association or other recognized accrediting agencies and/or holds a current valid certificate from the National Commission on Certification of Physician's Assistants, and who is legally authorized to provide any physician services, as defined in section 1861(q), in the jurisdiction in which such services are provided."

(5) Add a new subsection (bb) to read as follows "the term physician assistant services (notwithstanding those services covered in subsection (aa)), means such services as would otherwise be covered (under subsection

(s)(2)(a)), provided that such services are rendered under responsible physician supervision and that the physician assistant is legally authorized to provide any physician services, as defined in Section 1861(q) in the jurisdiction in which such services are provided."

THE PENNSYLVANIA STATE UNIVERSITY,
COLLEGE OF AGRICULTURE,
University Park, Pa., March 24, 1977.

Hon. Dick Clark, Chairman, Senate Rural Development Subcommittee, U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: In accordance with your request, I am sending my views on your bill (S. 708) which would permit Medicare reimbursement to rural health clinics for services provided by nurse practitioners and physician's assistants. Except for one concern, which I will mention later, this

bill has my enthusiastic support.

During the past several years I have participated in innumerable conferences, workshops, and meetings in which various proposals for alleviating the rural health problem have been discussed. With one exception, every proposal has generated considerable, and sometimes bitter, disagreement. The exception is the unanimity expressed for third-party reimbursement for services rendered by nurse practitioners and physician's assistants—even when these services are rendered in the absence of a physician's direct supervision. To wit, S. 708 is consistent with the position of the American Medical Association and the recommendations generated at the 1975 Conference on Rural America

and the 1976 Southern Rural Health Conference (1, 2, 3).

I suspect the exclusionary reimbursement provisions in the existing Medicare legislation was included out of a genuine concern for ensuring the delivery of high quality health care. It is unfortunate that this concern resulted in a universal judgment about an entire group of personnel involved in the delivery of health care. In short, the stipulation that Medicare will reimburse for services only when they are delivered under the direct supervision of a physician does not ensure quality—especially if the supervising physician is incompentent! If the concern is with quality, such mechanisms as Professional Standard Review Organizations should be further strengthened to evaluate the "final product" of the care delivered by individual practitioners—regardless of whether these practitioners are nurse practitioners or neurosurgeons.

Much research has been undertaken on the feasibility and desirability of making greater use of "new health practitioners," including nurse practitioners and physician's assistants. The conclusion that consistently emerges is that these practitioners have considerable potential for increasing the supply of

health services and decreasing their cost (4).

Although nurse practitioners and physician's assistants have a crucial role to play throughout the health care delivery system, they have a particularly promising role in rural areas because rural areas currently have fewer health care resources and in many cases cannot support a full-time physician. Even in those cases where a rural community can support a full-time physician, they often have difficulty in attracting and retaining a physician. These communities may not have as much difficulty in attracting and retaining nurse practitioners and physician's assistants. For example, Davis and Marshall found that only 7 out of 90 nurse practitioners trained at the University of North Carolina failed to return to the rural area which they agreed to serve at the beginning of their graduate training (5).

Of course it would be naive to suggest that S. 708 will solve the entire rural health care problem. However, it will do two essential things. First, it will enable the elderly to have greater access to health services being provided by nurse practitioners and physician assistants in those states which do not require direct supervision by a physician. Second, in these states it will lead to the establishment of additional clinics in areas that cannot currently support clinics because they are unable to receive Medicare funds. The establishment of clinics in these areas would obviously benefit persons other than just the

elderly.

The importance of Medicare reimbursement in providing the margin of financial support needed to ensure viability for rural health clinics should not be underestimated. A detailed study of an Oklahoma clinic staffed by physician's assistants found that the clinic was medically feasible but was an economic failure. Moreover, the evidence strongly suggested that the inability of the clinic to receive Medicare reimbursement was a fundamental reason for its financial failure(6). This should come as no surprise when one realizes that rural areas have a relatively large percentage of elderly. In addition, community owned and operated clinics typically serve a disproportionately large share of the elderly—especially in communities where privately practicing physicians refuse to accept Medicare patients.

The effect then, of enacting S. 708 is quite clear in those states where nurse practitioners and physician's assistants can currently deliver services in the absence of the direct supervision of a physician. But what about in those states where state statues effectively prevent nurse practitioners and physician's assistants from delivering services unless a physician is giving direct supervision? In these states, S. 708 will provide an incentive for states to re-

peal these restrictive statutes.

My arguments in support of S. 708 assume that patients and those in the medical profession are willing to make effective use of nurse practitioners and physician's assistants. Fortunately, this assumption is supported by extensive research findings. For example:

1. Leadley's survey of rural adults in Pennsylvania found that 90 percent of adults would willingly accept medical help from a physician's assistant(7).

2. McCoy, Green and Grinstead's Arkansas study found that 63 precent of those persons 65 years of age and over would willingly use a physician extender (8).

3. Lairson and his colleagues at the Kaiser Foundation found that physician's assistants were generally well accepted by physicians, nurses, pharmacists

and patients (9).

4. The American Academy of Pediatrics found that over one-half of the pediatricians they surveyed believed an allied health worker should make home visits in follow-up of acute illnesses and for patients with chronic disease, and should provide medical advice on minor medical matters (10).

5. Fottler and Pinchoff found that only 8 percent of the health care administrators they surveyed felt a nurse practitioner would not be an asset to

their institution (11).

It seems to me that the arguments are overwhelming for permitting Medicare reimbursement to rural health clinics for services provided by nurse practitioners and physician's assistants. What is not as clear is how the level of reimbursement should be determined. I would argue strongly for reimbursement on the basis of the cost of providing services. However, this approach, in purist form, does not provide an incentive for cost containment and efficiency; and must therefore be supplemented with appropriate guidelines, and/or other types of incentives (such as prospective reimbursement) which will ensure efficiency in the delivery of services. The alternative to reimbursement on the basis of cost is to base the level of reimbursement on "prevailing" fees or charges. Unfortunately, the market for health services is so imperfect that there is often times little relationship between the cost of providing services and the prevailing fee for those services.

Finally, I would like to comment on the only significant reservation I have about S. 708. This reservation is the failure of S. 708 to extend Medicare reimbursement to physician's assistants and nurse practitioners in urban areas. Although these personnel have particularly promising roles to play in rural areas, I see no good reason to confine their potential to rural areas. Surely, urban residents should also be allowed to benefit from the decreased cost and increased accessibility that can result from more extensive use of physician's assistants and nurse practitioners. In short, if quality health services are being provided and the consumer is satisfied with those services, then the provider should be reimbursed regardless of whether she or he practices in a

rural or urban area

Let me close by thanking you for the opportunity to express my views. Please feel free to call on me if I can be of additional assistance.

Sincerely,

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STATEMENT OF WILMA NICHOLSON, R.N., AND LARRY PAGETT, CHAIRMAN-TRUSTEES, SOS HEALTH CENTER, SEELEY LAKE, MONT.

The Seeley Lake-Swan Valley Hospital District DBA as the SOS Health Center has been in operation for the past six years servicing a 90 mile stretch of Montana's logging, ranching and resort area that extends into three counties, Missoula, Powell and Lake.

The Health Center is the primary source of health care services to all age groups and encompasses all services, home care to the elderly, emergency services, all school services to three schools, screening clinics and referral treatments from physicians, of which the nearest is 60 miles distant in Missoula, which is also the base of the nearest hospital.

We are located in a mountain valley which is frequently isolated by abundant snowfall and treacherous road conditions and further complicated by the fact that there is no public transportation to or from the area which makes

mobility for the elderly even more difficult.

The Health Center is staffed by a well qualified community health nurse that prides herself in the fact that almost all of the elderly in the community she serves, are able to remain at home due to the quality of home health care services she is able to provide even to those chronically ill and bedridden with severe debilitative diseases.

These services at present are being paid to the nurse by Medicaid, Workmen's Compensation, AARP and many other private insurance carriers. In fact, in the past six months "Skilled Nurse Facility" has been listed as a provider on

some of the insurance forms we have received.

Medicare payments have been paid to the Center for emergency transports of the elderly with conditions such as, G.I. bleeding, fractured hip, fractured femur and heart attack. And so it seems unreasonable that preventative health services and treatment such as blood pressure checks, suture removal, dressing changes, simple lab work and nutritional information which can be a severe problem with the elderly, combined with the isolation and the loneliness in a community such as ours, is not being paid by Medicare.

The Center also provides field experience in community health for student nurses from the Montana State University at Bozeman and gives them the rare opportunity to see a well trained nurse using all her capabilities to the fullest extent in a rural health setting and should be reimbursed by Medicare funds for their services.

My time to get this to your desk is short. I feel confident that you will support this bill as the need in rural health areas is critical and many guide-

lines for assistance are so stringent.

WAHOO CLINIC, Wahoo, Nebra., March 23, 1977.

U.S. Senate Committee on Agriculture and Forestry, Washington, D.C.

Gentlemen: Thank you for your request for my input into the rural health clinic bill hearing. I am Ivan M. French, a family practitioner in Wahoo, Nebraska for the past 30 years and son of a family practitioner in Holt

County, Nebraska, practiced there for 35 years.

We have been involved in the past several years in the training of physician's assistants by the School of Allied Health at the University of Nebraska Medical Center, Omaha, Nebraska, and have had several of them as preceptees in our office. One of the graduates of the program and a previous preceptee in our office, Patricia Decker, has been employed by us for the past year.

There are two nursing homes within two blocks of our office. We are required by various outside agencies other than nursing home personnel and families and patients to provide various services at the nursing home. Either in the guise of giving care considered to be adequate by outside parties or

certifying as to the adequacy of care provided to outside parties.

We have considerable difficulty in being reimbursed for these things on general principles because the person who requires the examination apparently is not the person who pays for it. Because we are having difficulty at the moment attracting young doctors to this area, and because the youngest doctor in our county died approximately a year ago, we have seen fit to employ a physician's assistant.

It is our feeling that one of the ways that this physician's assistant could be of help to us would be to assist in the providing of care to the nursing home patients and to call to our attention any things that required our atten-

tion.

It is our understanding that since we would be within two blocks of where the services were to be rendered, and since one of the doctors in the office would be calling at the nursing home on a weekly basis and that the patients could actually be brought to the clinic by auto or wheel chair in many cases, that it would be proper for our physician's assistant to render some of this

care without our physical presence being at all times necessary.

At the present time, our physician's assistant and our Clinic are getting around this problem by having the patients brought from the nursing home to the Clinic so that we can meet the criteria of physically being present in the building; and we do actually see the patient with the preceptee with the physician's assistant, but do not necessarily conduct every part of the examination or write out every part of the examination in our own handwriting.

I am sure you know that one of the problems in rural medicine today is the need to document everything that is done. I think most doctors feel that the documentation of what they do requires at least as much time and expense as the actual performance of the service, and this is of course one of the things that is increasing the cost of medical care. Documentation, as you well know, is required by governmental agencies and to protect ourselves from the constant threat of malpractice or of not having rendered the services billed for.

I am sure that you can realize that this is a rather unusual situation in that the consumer as for example the government gives both the specifications and the price.

It is my understanding that in the business world in general, if one sets up the specifications that the price is determined by the provider and if the price is determined by the consumer then the services should be determined by the provider as to what is reasonable for the price allowed.

I am sure that you also know that the payment that third parties give us is, at least governmental third parties, such as Medicare and Medicaid is arbitrarily decided by them as is the quality, quantity, time, and other spec-

ifications for services.

I think that the legislation considered in bills 708 would help the practitioner in the rural area to carry out his obligation to the nursing home and other handicap persons of the area. I think that reimbursement should be made to the physician or clinic who employs the physician's assistant and who pays his salary. I think that the patient, the nursing home, the physician's assistant, and the physician should be able to work out what they consider to be appropriate legal arrangements for the care and reimbursement of the nursing home and other residents of the community who are under Medicare and Medicaid. We are required to be certified as supervisors and employers of Physicians' Assistants and the conditions under which the physician's assistant and we operate are set down by the licensing bodies of the State of Nebraska. We feel that it would not be unreasonable if Medicare and Medicaid would accept the same conditions as the licensing board of our state considers to be appropriate.

Sincerely,

IVAN M. FRENCH, M.D.

HASTINGS FAMILY PRACTICE, P.C., Hastings, Nebr., April 1, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, Russell Bldg., Washington, D.C.

DEAR MR. HARF: I am writing this letter to express my opinion and viewpoint with regard to the Medicare Programs Prohibition of re-imbursement for physician's assistants or nurse practitioners when these services are under appropriate supervision of a medical doctor. My primary interest in this is a personal one and a practical one for I employ a physician's assistant in my practice. The refusal of the Medicare Program to re-imburse my physician's assistant for his services through me has curtailed the amount of help my physician assistant can offer me to a great extent.

I would like to give you some background about myself. My name is Earl J. Dean. I am in family practice in Hastings, Nebraska, a town of about 25,000 population. I have been in practice for approximately 22 years, the last 17 years in Hastings. I am Board Certified by the American Board of Family Practice since 1971. I am a member of the State Medical Association and the American Medical Association. I am a delegate to the State Medical Association from Adams County Medical Society and I am a member of the Board

of Directors of the State Academy of Family Practice.

Within the past two years Hastings has lost a number of its doctors due to old age, retirement, moving away by doctors to go into residency training, etc. Thus, we have found ourselves especially short of primary-care doctors. Last Spring when I first hired a physician's assistant, Mr. John Barta, there were only four family practitioners in the entire City of Hastings with a population of 25,000 and a drawing area in the rural communities around Hastings of probably 75,000 people. There are no obstetricians in the town so that among the four general practitioners we also do all of the deliveries. We also only have four internal medicine specialists in town; one of whom is elderly and one of whom restricts his practice to cardiology, so that we have an acute shortage of primary-care doctors. We do have a number of specialists in other areas but this does not help the problem of taking care of people's ordinary every day needs; such as the family practitioner does. For this reason, I felt that perhaps a physician's assistant might be one good way to help provide some of this care, therefore, I hired Mr. John Barta, a physician's assistant.

Mr. Barta has proven to be very competent. Among the duties which he is allowed to do by his certificate of the State Bureau of Examining Boards under my supervision are routine calls to nursing home patients for whom I am the attending physician. However due to the stand which the Medicare Program has taken of not allowing re-imbursement of services by Physician's Assistants, I have not been able to utilize Mr. Barta in that fashion. We were not aware of this problem when Mr. Barta started working for me and he made a number of visits to the nursing homes and proved to be very competent at this. He was very well liked by the patients there and did an excellent job. However when we were informed that this was illegal by the Medicare Program standards, we immediately discontinued it. We also were forced to go back and discount all charges which had been made for his services, although, we were not questioned on this matter by the Medical Program but felt we probably would be if we did not do this. In effect this has completely removed one of the major areas in which Mr. Barta would have been able to

be of service to me.

In addition it also affects his ability to see such patients in my office since if he sees such a patient, I must also go see the same patient and render some service to that patient which the patient can identify as a service by the physician. Obviously this is a waste of my time and effort and so Mr. Barta is not scheduled to see these patients. Again this limits his effectiveness. It is my understanding, and I may be mistaken about this, that there is no specific provision in the law which prohibits physician's assistants from being reimbursed for their services. There is no enabling statement present in the legislation which states that they may be paid. It would appear to me that if this is the case, the Medicare Program has made a very arbitrary and grossly unfair decision in deciding that no re-imbursement may be made under these circumstances. I feel that they could just as well have taken the opposite stand-if no specific statement prohibiting such re-imbursement was present in the law that they could be re-imbursed unless such legislation stated that they could not be re-imbursed. I also find it very ironic that to the best of my knowledge most, if not all the physician's assistant program in the country and certainly the one at the University of Nebraska Medical Center, were initially started up with the aid of grants from the Federal Government with the idea that these physician's assistants would be able to provide services in cases where a physician was not available. After getting such programs well under way and having graduates of the programs out in practice; the Medicare Program is, in effect, now undercutting the effort of starting such programs by refusing to pay any compensation for the services of these physician's assistants on Medicare patients.

In summary, I think that the Medicare Program is being grossly unfair about the manner of re-imbursement for the services of a physician's assistant who is properly supervised by a physician. Also they are seriously undercutting the entire Physician's Assistant Training Program throughout the country. I feel that if legislation does not promptly correct this matter the Physician's Assistant Programs probably will die because of it. I would strongly urge your support for the passage of this legislation allowing Physician's Assistants who are under proper supervision of a physician to be reimbursed

for these services.

Sincerely yours,

EARL J. DEAN, M.D.

THE FAIRFIELD CLINIC, Fairfield, Iowa, April 6, 1977.

Senator DICK CLARK, Russell Bldg., Washington, D.C.

DEAR SENATOR CLARK: Thank you for including me in your recent mailings regarding the Rural Health Clinic Bill. I believe the lifting of the necessity of an M.D. being present for physician extendors to receive remuneration from Medicare is necessary for some areas of the country. I would hope that the bill would continue to make sure that Medicare holds a physician responsible for the actions of his extendors so that it would not create another layer of professional licensing by state certifying boards. I know that phy-

sicians will cringe under the increased liability of having people away from them acting in their behalf, but I think the mantle of responsibility still rests more properly on the shoulders of those who have been trained to take that responsibility and have been used to administering it. The alternative would open Medicare to layer after layer of peripheral health care personnel administering treatment that may or may not be necessary, and possibly even dangerous. I think the people in rural America deserve higher quality medical care than the standard that would eventuate from such a program. Keep the doctor responsible.

Sincerely.

JAMES H. DUNLEVY, M.D.

WAYNE COUNTY HOMEMAKER, HOME HEALTH AIDE AGENCY, Corydon, Iowa, March 28, 1977.

Re Senate Rural Development Committee. Senator RICHARD RAMSEY. State House, Des Moines, Iowa

We note this hearing concerns the subject of Medicare reimbursement or rural health clinic services. The whole thing centers around our primary concern—the rural patient in his own home and the health (and home care) he receives.

But not one word is mentioned about the Homemaker-Home Health Aide. We see this as an effective alternate to inappropriate institutional care.

Homemaker-Home Health Aide service helps families to remain together and elderly, ill or disabled persons to remain in their own homes when a health or social problem occurs or to return home after specialized care. The trained homemaker—home health aide who works for a community agency carried out assigned tasks in the family's or individual's home under the supervision of a professional person who also assesses the need for the service and implements the plan. Many homemaker-home health aide agencies are, by contract, part of certified home health agencies.

Homemaker-Home Health Aide service may be the only assistance required by an individual or family or it may complement and facilitate other

needed services.

Unlike service in hospitals or other institutions, home care can be used flexibly and only those tasks will be assigned that cannot be performed by the individual or his family. Is this service cost effective? What an individual

can do for himself, we don't have to pay someone else to provide.

While saving the valuable time of busy and more costly professionals, the aide also add their own dimension to the care team in part because they spend far more time in the home than any other members of the team. Frequently the patients and the family find the paraprofessional easier to relate to because of similarities in their backgrounds, so that the homemaker—home health aide often is an important bridge between the professional team members and his family.

For aging persons who live alone are miles from any other family members, or whose available family members are themselves frail or ill, and also in households where there is terminal illness, the assistance of a homemakerhome health aide and other in-home services can greatly enhance the quality of life of the patient's remaining days as well as that of the family. The importance of a calm, security-giving, care figure in the home can be critically important whether the patient is young or old or somewhere in between. Emotional support is a key function of this worker, as well as taking on everyday duties to physically relieve those who can't handle it all.

In-home services are the answer for the individual who can do part of his own tasks of daily living, or who has someone else in the home to lend a hand. Each home care agency knows when it is getting into the area of institu-

tional care cost-wise, when this becomes the case it is usually best for other possibilities to be considered.

Iowa presently has a viable unit for delivering a wide range of high quality services in most counties of our state. Each of these units could be expanded to provide one stop shopping for the whole range of in-home services, either by direct service or contractual or referral agreement mechanisms, if reim-

bursement for the needed service were available.

Funding sources are presently too fragmented to encourage this kind of comprehensive service. Title XVIII, XIX, and XX of the Social Security Act have some funding available for Homemaker—Home Health Aide services. Title III of the Older Americans Act is another source. However, all of these funds have their limitations so that only some individuals can qualify and all have limited appropriations, as well.

In our agency we are utilizing six sources of state and federal monies. The necessary bookkeeping and the number of persons running in and out to monitor and review and audit are abominable. A uniform accounting and reporting system is badly needed. Many agencies go through costly recording and bookkeeping gymnastics required to provide a unified service while keeping the funding sources properly segregated and accounted for. A unification of federal funding for in-home services would surely be a boon to consumers. Also, it would lessen the administrative work now required by agencies and would therefore be more cost effective.

Please consider us.

Sincerely,

CAROLYN WILLEY, Director.

GUTHRIE COUNTY, IOWA, April 4, 1977.

DAVID HARF, Office of Senator Dick Clark, Russell Bldg., Washington, D.C.

DEAR MR. HARF: Because of my concern about Medicare reimbursement, I would like to express my opinion regarding to Senate Bill S. 708. In the rural areas we have a particular need for health care as it is not being fairly administrated.

For example, in our West Central Mental Health Center the law says reimbursement only qualifies when a doctor is on the premises. For us this is two

days a week on Title 19. This is how we operate, following the law.

Other centers that I know of has a doctor coming in for half a day to sign all the claims and they get reimbursement. This is against the law. We also have clinics that have nurses and physician assistants in charge and this also does not qualify unless a doctor is on the premises.

In discussing this with Social Services last week they made the statement that there are ways to get around the law. I object to any law that it takes technical people to work angles to circumvent the laws. Laws should be so stated that the poor people, without legal assistance, can understand it and be able to participate in it.

Our main problem today is that our laws are not for all the people, just those who have money and influence and will fight with legal assistance to

get more than their share.

We have in our county a poor family, by any standards. She had a headache and went to the doctor. He sent her to Methodist Hospital in Des Moines. She had a blood clot on the brain. Her bill has been terrific, over \$30,000. Social Services applied for Medicare for them. The upstarts that considered their application said they had too much security. They were farmers with old machinery and rented only 120 acres. They added cows, calves, hogs, soybeans and corn and came up with \$600. too much money. They would not consider a note to the bank for \$4,500 and \$2,000 accumulated in debts for crop year 1976 to oil company, seed and fertilizer companies and other natural expenses for farmers. Her husband is 55 years old. They have a 25 year old boy in a wheel chair.

How could they sell out and really pay a small portion of their big bills and have a future because they could not take any regular employment because of this boy? So they have become dependent on the county.

We need some people managing our affairs with common sense, not some young people out of college that do not even know what life is about deter-

mining who gets what.

Somehow our lives are being controlled by laws made mostly from appointed people and commissions, enforced by young people who were raised with a golden spoon that have no sense of practicality whatsoever.

I think it is surely time to stop and reconsider what this is doing to our public. Thanking you for this consideration, I am Respectfully,

VERNE SUMMY. Board of Supervisor.

P.S .- Another problem I know about is hospitalization and death and collecting from Medicare. In our family the application was submitted 3 or 4 times before it was paid. No real reason for it being sent back, no changes. It also happened to my brother-in-law's family. Beside being hard on the surviving spouse it could cut down on labor considerably if they used reason with these applications. Maybe they are trying to make this job look very important.

WASHINGTON, D.C., March 19, 1977.

Senator DICK CLARK.

Chairman of the Senate Rural Development Subcommittee, and Senator Patrick Leahy and David Harf Legislative Assistants.

DEAR SENATOR CLARK AND PATRICK LEAHY AND DAVID HARF: I read your letter of March 7, 1977 on the subject of Medicaid reimbursement for rural health clinic services with great interest and in my opinion Bill S. 708 to permit such Medicaid reimbursement to rural health clinics for primary health

services is an excellent idea.

I personally have petitioned Congress and the FDA through the Secretary of HEW to change FDA regulations to permit ordinary citizens to purchase antibiotics in small quantities—capsule or nose drop form without a doctor's prescription. Since the antibiotic medicines have been certified by the FDA as-"efficacious and safe" for the treatment of respiratory illnesses including in-fluenza as well as a host of other common illnesses for the past twenty years, according to Title 21 Code of Federal Regulations and as published in the Federal Register by the FDA.

I think that your bill also addresses the same problem of making availableto the general public or at least to those with Medicaid and Medicare Cards that health care that they could not obtain through other sources. And I realize that this situation is particularly critical in the rural and remote areas of the United States where people because of their poverty are more in need of health care than are people living in the more affluent areas of the country who enjoy a higher standard of living and live in healthier circumstances in general.

It may well be, however, that no law may be totally effective in the medical health care field whether health services are provided by the physician or the physician extenders, if neither are willing to issue those medicines that cure the patient of his illness. And in many many instances the most effective

medicines are the antibiotics.

I note with interest that the provisions of your bill make it possible toreimburse physician extenders for the services that they provide when the doctors are not available. And of course it is really a necessity to make such health care extenders available to the sick when there is no doctor available

particularly in the case of the rural community.

I wonder, however, if I understand the precise meaning of reimbursement? Does that mean that the medical services providers will receive an additional income on a fee per patient treated basis or will the person receive a supplement to his income for participating in the medicaid or medicare program? I would like to suggest the latter course of the federal government supplementing the income of the health care services providers by several thousands of dollars per year each where such services are being rendered by medical health services providers under state, county or city programs that now exist. I would suggest that similar programs be set up in rural communities where they are not available and that those health care providers be paid by the federal government at the medium income for health service providers in their particular category throughout the country plus the additional raise in annual salary, particularly in those states which are too poor to set up their own health programs for the poor in the cities and in the rural areas. And I commend highly the provisions of the present bill which recommend the continued liaison between the health providers and the physicians. There is no substitute for the physician and it is only because of the shortage of physicians willing to work in the rural areas that such a program is necessary in the first place.

I would like to express my ideas also on providing mobile health units that are equipped much more extensively and at times even equipped with a

trained physician.

But before I do I would like to discuss briefly another problem.

At present time the way medicare and medicaid is structured on a fee paying basis and for the participating physician the programs act as a Welfare Program primarily for the benefit of physicians that is subsidized by the federal government. Now those physicians are normally among America's highest paid professionals generally averaging \$40,000 dollars per year. However, with the addition of medicaid and medicare fees, this income has increased in some instances by as much as \$400,000 dollars per year which is a substantial sum for a federally funded medical health care program that was designed among other things to help the sick and the poor.

I would suggest that one way that this abuse, if it is an abuse could be corrected is to propose that doctors working under medicare and medicaid programs be paid an annual full time or part time salary that approaches the national average for physicians on an annual basis or the time that such

physicians worked.

I consider the case of the fee charging surgeon particularly dangerous to individuals when they are ill and may or not need surgery because there is a long established tendency for such surgeons to work more for motives of profit and thus to perform excessive numbers of unnecessary surgery. (I have been informed that one medical group insuring hospitalization has its own doctors and surgeons who do work on an annual salary commensurate with their skill as physicians and surgeons and that in general this groups medical costs are lower and the results generally better with respect to the treatment and cure of the patients diagnosed and treated.) So I would suggest the need to require a law that the surgeon be paid on a salary basis according to their demonstrated skill and experience. Such a law would tend to discourage unnecessary operations that are now performed because of the individual surgeons fees that are derived from the well to do patient or from those under medicaid or medicare.

While on the subject of sometimes surgical fraud and maiming, I do not wish to sound too hard hearted or impractical. I realize, for example, that particularly medicaid has been used in some instances as a means of helping the poor elderly sick or not so sick patient. And when such practices have for their aim the helping of the elderly in dire or near dire straits, I think that

such practices are good.

I would like to suggest though, that authority to aid the poor and particularly the elderly as they are encountered through medicaid programs would be better handled by a social worker, working within the same program. And I feel that such would be true in the case of the rural regions where besides the doctors and the medical services provided there should also be social workers to help the poor by offering economic assistance where they are in dire straits or the illnesses that they have are a derivative of mal-nutrition and hunger. Of course the doctor or physician extender should also have the legal right to ask the state to refer monetary assistance where the condition and the circumstance of the patients indicate that such is necessary. The principle advantage of social worker being that when people are hungry and in need of money they should not have to pretend to be sick or to undergo major or even minor operations to obtain that help.

The problem of the physician extenders of course is the problem of the professional versus the semi-professional. And it is not an easy problem. Given the circumstance of honest and well trained physicians—persons trained in the latest techniques of modern medicine, such professionals would of course be preferred in all instances to physician extenders only partially trained in adequate medical care. However, the history of medicine as it is practiced in America has indicated that not all American doctors are honest, regardless of the superior training and statistics would indicate that in some instances today the physician extenders can do a better job where he uses the best of the modern medicines which often times the skilled physician will

ignore as a too simple and mundane medical technique. This is particularly true with respect to prescribing antibiotics particularly in capsule or nose drop form which are capable of curing a host of respiratory illnesses and fevers that other medicines can not cure. Perhaps new laws could be passed that train physicians in four years time for medical doctors and for seven

years including a year of internship for surgeons.

In any event I do think that the Congress should give consideration to training physician extenders to upgrade their skills by state and federal government programs to upgrade their professional skills up to finally the level of physician. It would seem reasonable to assume that there should be such a program for those working in the field of medicine who are not doctors but who nevertheless are not unwilling to extend themselves by work in the field as are many physicians who prefer to practice medicine only in their office or occasionally in surgery rather than making it a practice to visit the sick and chronically ill as do the physicians extenders.

However, all of the medical programs for doctors and physician extenders etc. would be of little value, however, if neither the doctors, the nurses or paramedics do not provide the proper medicines and perform the proper procedures when they are necessary and this is true certainly in the use of

antibiotics in many instances to cure the patient.

I therefore think that the provision of your bill that would give the physician extenders medicine dispensing powers and facilities is an essential element of your bill particularly in rural areas where the distances are long and the physician extenders may be the only medical practitioner that the patient

may see.

I would also like to suggest that for many recognized common illnesses that specific common antibiotics such as tetracyclin and penicillin, and teramycin be given as the first medicine for those known respiratory illnesses and fevers such as Rock Mountain Spotted Fever as well as the measles and the mumps. The reason for this being that the FDA long ago and continuously has conducted tests which indicate that such medicines are the most effective medicines in curing common illnesses. And common sense should indicate that they should be used first.

I mentioned before the idea of mobile units in cases of remote areas or where distances are too long to hospital or urban health facilities. Such large medically equipped trucks, boats or helicopter could be equipped in some instances for even the performing of minor surgery which would be useful in

farm areas or to victims of highway accidents.

These are some of the ideas that I thought might be incorporated into your

bill or into similar bills in the field of health care.

In any event I do think that the present Bill S. 708, even in its present form is a bold step in the right direction of guaranteeing rural America that they will be given the health care services that are available to the community in

general under the medicaid and medicare program.

I do worry though that all of those programs could be functioning and still the sick person might not be able to obtain antibiotics even in capsule form or nose drops that they need. Not even when the patient himself has requested such medicine. I think that you as legislators should address yourselves to this problem, not only for the sake of the rural communities but for the sake of all American people. Because over the past twenty years the FDA has Certified from before 1961 in the Federal Regulations Title 21 under "Antibiotics" that the antibiotics cure influenza and a host of respiratory illnesses. Yet doctors do not in many instances make such medicines available to the patient sick with those illnesses.

And again I wish to emphasize that when a person is seriously ill or seriously injured that there is no substitute for a well trained and honest physician who can provide the proper medicine and treatment. However, when such experienced and honest physicians are not available, it is certainly of great help to the sick to have a person who is available who can administer the proper medicines or prevent shock until the physician is available for further treatment.

This is particularly true for those patients with common illnesses which can be treated effectively by antibiotics in capsule or nose drop form. Yet wherever possible of course a person prefers the trained physician particularly

when he works honestly with the medical laboratory and determine scientifically the most effective remedy for the illness and in most instances that medicine is an antibiotic administered in capsule form. However, if the doctor is more concerned with finding the cause of the illness rather than finding the cure, then he has placed his primary emphasis on scientific investigation rather than on the goal of medicine which is the cure of the patient.

I therefore wish to thank you Senator Clark and members of your committee and all of your staff, my appreciation to your committee for informing me of Bill S. 708 and asking for my comments on this subject. Thank you and your committee for the great work that you are doing for the American

People in the Health Care Field.

Sincerely,

SAMUEL B. WALLACE.

P.S.—Because of my experience working as a medical technician in Brazil, I might be able to help your committee further in the field of medicine by using my own knowledge and experience, I think I could analyze some of the medical treatments to determine if they are in accord with the best scientific evidence in the field of medicine by revealing findings in the medical journals and treatments recommended and tested by the leading pharmaceutical laboratories and by the FDA.

> LOUISIANA HEALTH AND HUMAN RESOURCES ADMINISTRATION, OFFICE OF THE COMMISSIONER, Baton Rouge, La., March 22, 1977.

Hon. J. BENNETT JOHNSTON. U.S. Senator, U.S. Senate, Russell Senate Office Bldg., Washington, D.C.

DEAR SENATOR JOHNSTON: The following is in response to your request for comments and questions on S. 708.

This legislation would allow medicare reimbursement for rural health clinic services provided by nurse practitioners and physicians assistants. It would stimulate an increase in health manpower and would encourage states to develop mechanisms for nurse practitioner/physician assistant certification and regulation. Most important is the potential increase in the quantity and quality of medical services available in rural areas. For example, there could be a reduction in the incidence or severity of those illnesses which are alleviated by prevention or early intervention. There could also be a reduction in costs for inappropriate hospitalization and medical related transportation. This would occur by providing those services and follow-up care which does not have to be hospital-based in the outpatient setting of a rural health clinic.

REIMBURSEMENT

The question of reimbursement is a difficult one. However, there is an attempt by the Bureau of Health Insurance in the Social Security Administration to address both impact of the physician extenders (nurse practitioners/ physician assistants/medex) on the delivery systems and alternative methods of cost reimbursement. This two-year study began in 1975. It focuses on the impact of physician extender utilization on the delivery of primary care; and, the effects of alternative methods and amounts of reimbursement for physician extender services upon practice productivity and the costs of care for medicare Part B beneficiaries. Three types of experimental reimbursement were planned: (1) 100 percent of the physicians allowed medicare reimbursement; (2) 80 percent of the allowed reimbursement, and (3) an average net cost-related reimbursement. The results of this study should afford sound information on which to base a mechanism for reimbursement.

CLINIC REQUIREMENTS

The basis requirements for rural health clinics services should allow for the small one physician extender clinic as well as larger clinics having more physician extenders and additional allied health staff. In either extreme, the clinic must have those elements included in the definition of a facility: phy-

sician supervision of physician extenders; and arrangement with one or more physicians for regular reviews of all medical services provided by the physician extender; availability of physicians for referral and consultation; maintenance of clinical records on all patients; written policies to govern management of the clinic and all services it provides; and procedures for utilization review. The interpretation of those elements should be broad enough to insure the survival of a one physician extender clinic and narrow enough to insure quality care in all clinics.

CERTIFICATION

National certification standards and program accreditation for physician extenders are quite new. Therefore, certification for medicare reimbursement should be based on training, education and experience requirements prescribed by the Secretary's regulations in accordance with the respective state law and regulations to allow for maximum utilization of all qualified extenders in a given State.

CONCLUSION

S. 708 would open access to medical care for the rural population. However, it must insure both quality and cost reviews for these are essential in the operation of an effective and efficient health services delivery system. Strong criteria for quality of care must be developed and implemented. Both utilization and costs monitoring must occur. Issues of quality, quantity and costs must be addressed if a real impact is to be made on rural health problems.

If my staff or I can be of any additional help, please let me know.

Sincerely,

WILLIAM H. STEWART, M.D., Secretary.

RURAL AMERICA, Washington, D.C., March 29, 1977.

Hon. Senator DICK CLARK, Russell Senate Office Bldg., Washington, D.C.

DEAR SENATOR CLARK: Thank you for asking us to comment on S. 708, a bill to provide Medicare reimbursement for the services of physician extenders practicing in rural health centers. We are delighted to have this opportunity to share our views with you and other members of the Rural Development Subcommittee concerning this proposed legislation.

From your work in the Senate, it is clear that you are well aware of the urban bias of the Medicare program. We would like to commend you and Senator Leahy on your efforts on S. 708. This bill represents a crucial modification of Medicare to recognize the important role of physician extender clinics in rural areas and to assure that the rural elderly have financial access to clinic services.

COMMENTS ON S. 708

Your proposed legislation would provide Medicare coverage for services provided by physician extenders in rural clinics. A physician would not have to be physically present when the services are provided. The clinic, would, however, be required to have an arrangement for the regular review by the physician of all services provided by the extender, the preparation by the supervising physician and physician extender of standing orders for treatment of patients, and referral and consultation with the physician for advice and assistance in emergencies. Experience clearly demonstrates that physician extenders operating under physician supervision as it is designated in S. 708 provide high quality health services.

Another extremely important provision of the bill is that payment for physician extender services would be made directly to the clinic and would be based on the costs incurred by the clinic in providing the services. These costs would include those direct and indirect costs of maintaining the clinic which are reasonable. This method of reimbursement would give much needed finan-

cial support to rural health clinics.

An additional very positive aspect of S. 708 is its broad definition of rural health clinics to be reimbursed under Medicare. The definition of "rural" on page 3, lines 14-16 of the bill is broad enough to include all areas in the United States that would be generally accepted as rural in size and by nature.

S. 708 also covers physician directed clinics.

We do have one area of general concern: the administrative and reporting requirements. We recommend that in the preparation of its committee report, the Congress takes into consideration the unique characteristics of rural clinics. The Secretary of DHEW should be urged to keep the related regulations simple and the bookkeeping requirements to a minimum in recognition of the limited administrative staff available to small rural clinics.

We are grateful for the opportunity to comment on S. 708. According to the response which we have received from our membership and other concerned individuals, this proposed legislation would greatly increase the access by rural people to health services. There is also much appreciation for the Rural Development Subcommittee hearings on this bill. These hearings give rural people an opportunity to comment on legislation of great import to their com-

munities.

Finally, we hope that as this bill is reviewed and modified, it will continue to reflect an awareness of the critical health service needs of rural America.

Sincerely yours,

NANCY E. COHN, Health Policy Coordinator.

STATEMENT OF RUTH E. KOBELL, LEGISLATIVE ASSISTANT, NATIONAL FARMERS UNION

I am Ruth E. Kobell, Legislative Assistant for National Farmers Union, 1012-14th Street N.W., Washington, D.C. We appreciate the opportunity to support legislation which would provide medicare reimbursement for phy-

sician extenders practicing in rural health clinics.

Mr. Chairman, we commend your leadership in holding these hearings to help shore up financial support of health care delivery in rural areas. Rural areas lack the needed doctors and other health personnel to deliver adequate health care even to those residents who can pay for such care. Many small towns and rural areas do not have the population density required to support a full time doctor. Yet their health problems are compounded by delayed attention to easily treated injury or disease because of the difficulty and expense of traveling long distances to reach such health care.

The members of National Farmers Union have urged improved health care delivery to rural areas for more than thirty years and have continued to point out, both in their policy statements and testimony to Congress, the disadvantages under which many farm families and other residents of rural areas must labor in trying to provide their health needs. Our citizens are medically disadvantaged if they do not have such care available, regardless

of income.

Skyrocketing health care costs are requiring us to focus on the ways in which quality health care can be delivered to those needing it at less cost and special attention is being given to Medicare and Medicaid procedures.

An article from the February 27 Sunday New York Times reviews some of the approaches to reimbursing hospitals for care to those covered by Medicare, pointing out "According to health care experts, a one-day reduction in the average length of hospital stay in this country would save nearly \$2 billion a year."

If we could move more rapidly to preventative treatment and monitoring which can be more accessible at local clinics, the savings could be even

greater.

Such savings are particularly important to our farm families who are always faced with fluctuating farm incomes and rapidly escalating health insurance premiums. Farmers today are experiencing collapsing farm prices, continued drought and heavy costs of a hard winter. Lacking national health insurance, support for local health service becomes even more important.

Delegates to our National Farmers Union 75 Anniversary Convention met in San Antonio, Texas on March 5 to 9, 1977 and adopted a policy that contained a comprehensive statement on rural health care. Following are appro-

priate sections of that statement relating to reimbursement and delivery of

health care in rural areas:

"We urge the Congress to go beyond the question of financing medical care in rural areas. Even if prepaid health insurance is made available to all Americans, shortcomings in the health delivery system can be a bottleneck, preventing timely care from reaching the medically needy. Federal scholarships for students in the health professions are vital to increase the number of doctors and health personnel, with provisions to encourage professionals to serve in rural areas. Federal grants and loans are needed for the operation of community mental health, alcoholism, and drug addiction centers and construction of facilities for direct service health plans.

"Greater attention should be given to the extension of health services to rural areas, including a rural health corps, expanded use of medical aides, paramedics, nurse-practitioners, and other innovative approaches so as to alleviate the scarcity of health personnel in rural areas.

"We oppose efforts to shift Medicaid and other federal health programs to the states without provision for maintaining equality and availability of service. Such a shift would worsen the maldistribution of health care without

reducing costs to the consumer or taxpayer.

"We urge expansion of programs to provide home health and housekeeping services under Medicare and Medicaid to those who need it in order to make it feasible for many to delay or prevent their commitment to nursing homes or other institutions. We urge enactment and enforcement of uniformity adequate but practical nursing home standards for facilities, professional and subprofessional care, and rates."

Rural health clinics staffed by physician extenders can and, in many instances, do provide the preventative health services that decrease the incidence of illness and improve the health of the citizens of the community. A senior citizen needing such help as blood pressure monitoring can get to a local clinic but may not be able to afford or have available transportation to the nearest doctor's office. The time and effort involved in travel, waiting in line for a few minutes time of an overworked doctor or the service of an office nurse many times seems more of an effort than it is worth.

Public transportation is nonexistent in many rural areas and many older

people covered by Medicare and Medicaid do not have private transportation, either because they can no longer afford a car, or are no longer able to drive. Pride and independence make it hard to ask their neighbors to take them to town and wait for them to get any but the most pressing medical care.

Mr. Chairman, we appreciate your recognition of the flexibility needed in proposing that Medicare reimbursement be provided to clinics which have been set up and operated in a variety of patterns. One such example is the community clinic which was established by the citizens of Dove Creek, Colorado, a small isolated community in the southwestern corner of the state and staffed with the help of the National Health Service Corps. The story of its organization was told in some detail by the Denver Post Empire Magazine. March 7, 1976, and I have attached a copy of my statement as an example of the efforts to which rural people will go to provide their families with needed care. Medicare reimbursement for services which could be provided by such a clinic would help provide the financial support needed to continue this worthwhile service.

Admittedly such financial support is but a first faltering step to assuring available health care to rural America, but as the Chinese proverb reminded us, "A journey of a thousand miles is taken one step at a time," and it appears that such a step is long overdue.

> BLUE CROSS-BLUE SHIELD OF IOWA. OFFICE OF THE CHIEF EXECUTIVE. Des Moines, Iowa, April 4, 1977.

Hon. DICK CLARK, U.S. Senate. Russell Senate Office Bldg., Washington, D.C.

Dear Dick: You asked for my further comments on S. 708 which would allow Medicare reimbursement for physician extenders and nurse practitioners in rural clinics.

Let me say I am pleased to note you have rallied thirty cosponsors to your bill, and I do hope that the legislation will move through the Congress as

rapidly as possible.

When the legislation was being drafted earlier in the session, I pointed out to you that several principles should be taken into consideration and I want to reemphasize those points. Blue Cross and Blue Shield believe that the relationship of employer to employee should be maintained in that the licensed physician is responsible for supervision of the physician extender. It is absolutely necessary that the authority for the patients' care must be with the supervising physician. With regard to direct reimbursement for services, the supervising physician—not the physician's extender—should be the recipient of payment.

There should be flexibility for another physician to be designated by the supervising physician to direct the physician extender or nurse practitioner when the physician is a member of the supervising physician's partnership, corporation, or clinic, or other legal entity, and when the delegation has been

approved by the Board of Medical Examiners.

It is also important that the current reimbursement methodology for professional services under Medicare be maintained in determining the level of

reimbursement for the provision of physician extender services.

I hope that these comments can be helpful to you in developing support for the passage of the legislation. I can assure you that we at Blue Cross and Blue Shield will continue to exercise our leadership position in Iowa's health care system to find improved means of service delivery to Iowans.

Sincerely.

DAVID S. NEUGENT, President.

THE NEBRASKA ACADEMY OF PHYSICIAN'S ASSISTANTS, Auburn, Nebr., April 4, 1977.

Hon. DICK CLARK. U.S. Senate.

Russell Office Bldg., Washington, D.C.

Dear Senator Clark: On behalf of the Nebraska Academy of Physician's Assistants, I would like to state our position on S. 708 which pertains to medicare reimbursement for physician extenders.

An amendment to the medicare law allowing for reimbursement to the supervising physician for services performed by his assistant is essential if

the physician assistant concept is to survive.

There are several points which require grave consideration: (1) the definition of physician extenders should be limited to those individuals who are certified by the National Commission on Certification of Physician's Assistants. All assistants assuming such an important role, including nurse practitioners, should meet the same high standards of competence already established by this Commission; (2) each assistant should be under the "responsible supervision" of a physician, that is, the physical presence or easy availability of the supervising physician. Independent practice by assistants is potentially dangerous; (3) Reimbursement should be made directly to the physician that employs the physician assistant. This reimbursement should be on a fee-forservice basis at 100% of the physician's customary fee; anything less than 100% reimbursement would give health care recipients the impression that they are receiving "cut-rate, low quality" health care.

There are many physicians in Nebraska currently employing PAs. These physicians are severely restricted in the efficient utilization of their PAs as a direct result of the present status of medicare reimbursement. Many other physicians would be more inclined to hire a PA if they would be reimbursed

for the services the PA provides.

Thank you for your efforts in attempting to rectify this situation.

Sincerely.

ROBERT A. WITT, P.A., President. UNITED STATES SENATE, Washington, D.C., April 20, 1977.

Hon, DICK CLARK, Russell Bldg., Washington, D.C.

DEAR DICK: As a follow-up to the concerns that I expressed about two items in the Rural Health Clinics bill which I co-sponsored with you, I would like to share with you a letter from the Vermont State Nurses Association. This letter voices concern over the two items which disturbed me in S. 708.

I would appreciate it if you would see that this letter is made part of your

hearing record.

Sincerely yours,

ROBERT T. STAFFORD, U.S. Senator.

Enclosure.

VERMONT STATE NURSES ASSOCIATION, INC., Burlington, Vt., March 30, 1977.

Senator Robert Stafford, Dirksen Office Bldg., U.S. Senate, Washington, D.C.

Dear Senator Stafford: The Vermont State Nurses Association is writing

to you in regard to the Rural Health Clinics Bill, S. 708.

Nurses throughout Vermont have long been concerned about health care in rural areas of this state. Public health nurses, perhaps more than any other health professional, have been the group on the forefront of bringing health care to rural areas. Now with the interest in ambulatory care centers, the advent of the nurse practitioner and the increased interest in rural health we

can hope for both quantity and quality improvements.

We would, however, like to point out to you two major concerns with S. 708. One is the lumping together of the nurse practitioner with the "physician extender". We object strongly to this terminology and wish to suggest that the language throughout the bill refer to the two distinctly different entities as such (nurse practitioner and physician assistant). The nurse is licensed and is responsible for his/her practice under the State Nurse Practice Act. The physician's assistant is not licensed and, no doubt, much more closely fits the description of "physician extender" for he/she must function under the supervision of a physician. Therefore, we do not believe it is at all appropriate to include nurse practitioners under the umbrella term "physician extender."

Our second problem with the Rural Health Clinic Bill is in the area of physician supervision. We wonder if the bill's language doesn't, in actuality, continue to restrict reimbursement only to the "supervised medical realm".

As you are aware, nurse practitioners bring to the system not only their more recently acquired knowledge in the patient's physical assessment but also the education and experience of registered nurses. This means they are uniquely well qualified to meet nursing needs. These nursing needs encompass prevention of illness, adaption to illness, maintenance of health and patient education. These *independent* nursing functions must be reimbursable.

In addition the nurse is uniquely qualified to identify pathology and deviations from the normal state of health. The pathology and deviations from health can then be handled through previously established nursing/medical protocols and/or then be referred to the expert in pathology—the physician for evaluation, consultation and assistance in formulation of a treatment plan.

The references in the bill to supervision fail to recognize the nurse as licensed and responsible for his/her own acts. It would seem that such terminology would again be restrictive and not be consistent with what we believe

is the real intent of the bill—to bring health care to rural America.

The Vermont State Nurses Association is hopeful that the aforementioned changes can be made in the proposal and we hope that you can be helpful to us with those changes as the bill moves through the legislative process. We would be happy to discuss these changes with you or you may want to talk

with the American Nurses Association's Government Relations Office in Washington.

Thank you. Sincerely,

CAROL FIELDERS, Legislative Committee.

TOWNSHEND, VT., March 21, 1977.

Hon. Patrick J. Leahy, Russell Bldg., Washington, D.C.

DEAR SENATOR LEAHY: The enclosed statement represents my personal views on S. 708, a bill to amend Title XVIII of the Social Security Act to provide

payment for rural health clinic services.

I have been a member of the board of trustees of Health-Care and Rehabilitation Services of Southeastern Vermont, Inc., since its establishment in 1968, and was its first president. However, the material relating to S. 708 was not received until March 18, and with written comments in lieu of personal testimony requested by March 25, it was not possible to submit this statement to the board for formal approval, although it expresses the views of individual board members.

This opportunity to testify in writing in favor of S. 708 is very much

appreciated.

Sincerely,

BERNARD W. SCHOLZ.

STATEMENT BY HEALTH-CARE AND REHABILITATION SERVICES OF SOUTHEASTERN VERMONT, INC., BELLOWS FALLS, VT.

COMMENTS ON S. 708

Background

Health-Care and Rehabilitation Services of Southeastern Vermont, Inc., is a private voluntary organization dedicated to the promotion of the availability of comprehensive health care and rehabilitation services throughout Windham and Windsor Counties, Vermont. Incorporated in 1968, it is a membership organization, paying its expenses entirely out of voluntary membership contributions and donations, and operating entirely with volunteer staff.

In 1969, the agency (HCRS) sponsored the establishment of a project for the identification, diagnosis and treatment of developmental disabilities in pre-school children. In 1972 this project was incorporated as an independent agency under the name Winston L. Prouty Center for Child Development.

In 1972, HCRS sponsored the establishment of a project for the provision of visiting nursing service, visiting homemaker service, and visiting physiotherapy service in five towns of the West River Valley in Windham County. In December of 1972 this project was incorporated as an independent agency under the title The Valley Health Council, Inc.

Also in 1972, HCRS sponsored the establishment of a project for the provision of comprehensive mental health services on a regional basis throughout Windham and Windsor Counties through the merger of two small existing mental health agencies with limited programs. On July 1, 1975, this project became operative as Mental Health Services of Southeastern Vermont, Inc.

HCRS is concerned about the fact that these three agencies are not functioning to their full potential due to the current restrictions on eligibility for payments under Title XVIII of the Social Security Act. HCRS is even more concerned about the inadequacy of available comprehensive health care in its service area. Statistically, there appears to be adequate physician coverage for the citizens of Vermont. Actually, however, there is a high concentration of medical professionals around the larger medical facilities, especially the University of Vermont, while certain areas of the State are without any medical care provisions.

There are several rural health clinics in Southeastern Vermont, such as Cavendish, Chester, Londonderry, and Wilmington. In the West River Valley, on the other hand, there is only a small private hospital with superannuated

staff and very limited facilities (according to a survey undertaken and published by the Connecticut Valley Health Compact, Inc., in 1969). Younger physicians have tried to become established to serve the citizens of the five towns in the Valley, but found the workload excessive, the remuneration inadequate, and left.

The Potential Impact of S. 708

1. HCRS is anxious to establish an H.M.O.-type rural health clinic in the West River Valley, and at the same time stimulate the integration of existing clinics, nursing and homemaker services, and mental health services into a comprehensive health-care network, covering its entire service area. If physician extenders could be located strategically in the service area, primary care would become accessible and available to persons currently out of reach of existing facilities, and physicians would be attracted to central clinic locations where referral to, or backup by specialists from not-too-distant medical centers would be available.

2. Present tentative plans call for the employment of physicians and physician extenders on a fixed salary, with reimbursement being made to the individual rural health clinics, unless these were consolidated in a regional

organization, in which case reimbursement would be made to the latter.

3. The policies and procedures established under the Community Mental Health Centers Act of 1975, as amended, appear readily adaptable to rural health clinics insofar as physician participation, arrangements for referral, and management policies are concerned, for the purpose of qualification for reimbursement.

4. Current requirements under Vermont statutes appear adequate for the certification of providers of re-imbursable services under the proposed legis-

lation.

The proposed amendment of Title XVIII of the Social Security Act, though not a panacea by any means, would be a giant step in the direction toward more rational health care in rural areas.

AMERICAN ACADEMY OF PEDIATRICS, Evanston, Ill., April 4, 1977.

Re Response to S. 708. Hon. Dick Clark, U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: The American Academy of Pediatrics wishes to comment on S. 708, a bill to amend Title XVIII of the Social Security Act to provide payment for rural health clinic services. Although the establishment of reimbursement policies for Medicare services is not directly related to the pediatric population, it may set a precedent that would affect compensation for health care services to children and adolescents. The Academy has been actively involved with the development and use of the physician extender in the specialty of pediatrics (i.e., the pediatric nurse practitioner/associate) since the inception of this concept in the mid-sixties. In the following comments regarding S. 708, the Academy's policies in relation to the pediatric nurse practitioner/associate apply to physician extenders in general and to all nurse practitioners/associates.

As pediatric nurse practitioners/associates are providing delegated medical services, proper physician supervision is essential if high standards of care are to be maintained. Accordingly, S. 708 should be revised as follows: Section "(aa) (1) The term 'rural health clinic services' means delegated medical services and required supplies as would otherwise be covered under subsection (s) (2) (A) as provided by physician extenders under physician supervision,

furnished. . ."

The American Academy of Pediatrics has adopted the following principles concerning reimbursement for delegated medical services provided by pedi-

atric nurse practitioners/associates:

1. Reimbursement for medical services should be made only when the pediatric nurse practitioner/associate functions under the direct supervision of a physician.

2. The mechanism of payment for these services should be to the supervising

physician or to the responsible health organization.

3. Reimbursement for services should be on the basis of type, quality,

and equivalence of service rendered, rather than who provides the service. The Academy established the policy named above with the intention of fostering supervised, collaborative practice between the physician and the pediatric nurse practitioner/associate.

We oppose reimbursement for medical services directly to pediatric nurse

practitioners/associates for these reasons:

1. The pediatric nurse practitioner/associate is performing delegated medical functions for which the physician has the ultimate legal and professional responsibility.

2. Direct reimbursement would encourage the development of independent practice by the pediatric nurse practitioner/associate which would lead to

fragmentation of health care.

3. The development of independent practice by the pediatric nurse practitioner/associate will interfere with the attainment of the highest standards of health care for children.

4. The development of independent practice by the pediatric nurse practitioner/associate will interfere with the integration of the child into an on-going system

of comprehensive care.

To ensure that the medical services provided by physician extenders in ural areas is of high quality, adequate physician supervision is essential.

rural areas is of high quality, adequate physician supervision is essential. The Academy finds Section (3) which defines "physician extender" restrictive. Although appropriate credentialing mechanisms are inherent in the recognition of health professionals, it is inappropriate for legislation to specify such credentials and to recognize particular organizations as the certifying bodies. Regulation of safe practice of health professionals is the legal responsibility of individual States; Federal involvement is unnecessary.

Included in the definition of "physician extender" are the terms "nurse practitioner" and "nurse clinician." The use of both of these terms in the legislation is inappropriate and misleading. As defined by the National Association of Pediatric Nurse Associates and Practitioners and the American Academy of Pediatrics "A pediatric nurse practitioner/associate is a registered nurse who has acquired advanced knowledge and clinical skills in nursing through successful completion of a formal program of study that was developed and continues to be a collaborative effort of nursing and medicine." (Enclosure A.)

The Academy does not believe that every "nurse" is a "nurse practitioner" (associate). In order to assume delegated medical functions and responsibilities, the nurse must be specially prepared in a program for which both the nursing and medical professions have coequal and ongoing responsibility. (Enclosure B.) For these reasons, the Academy strongly recommends deleting

"nurse clinician" from this definition.

Because of the importance of this legislation, the Academy welcomes the opportunity to discuss these issues with you in more detail.

Sincerely,

ROBERT G. FRAZIER, M.D., F.A. A.P., Executive Director.

Enclosures.

[Enclosure A]

DEFINITION OF A PEDIATRIC NURSE PRACTITIONER/ASSOCIATE

A pediatric nurse practitioner/associate (PNP/A) is a registered nurse who has acquired advanced knowledge and clinical skills in nursing through successful completion of a formal program of study which was developed jointly and continues to be a collaborative effort of nursing and medicine. The program will have met guidelines jointly established by the two professions.

PNP/A's have the competence to provide a broad range of primary health care services. They are jointly educated and trained by nurses and physicians to prepare them to function in an expanded nursing role in the provision of child health care and to prepare them further to provide selected health care services which traditionally have been the responsibility of physicians. In the provision of these delegated medical services, the pediatric nurse practitioner/associate does not function independently, but under the physician's supervision, direction and review.

[Enclosure B]

[From the Pediatrics, Vol. 47, June 1971, No. 6, Commentaries]

NURSES AND PEDIATRICIANS COLLABORATE

The Academy's Committee on Pediatric Manpower was established because of the concerns of Academy membership about the numbers of American children who were not receiving health care and the tremendous pressures for service being placed on practicing pediatricians. The Committee recognized that solutions to these problems would be complex and multifaceted. One of the solutions which it chose to pursue in some depth was that of the interprofessional care of the ambulatory pediatric patient. This concept involves what is often referred to as an "expanded" role of the nurse, working in close collaboration with the pediatrician. The concept is of equal importance to the nursing profession, a large segment of which has come to deplore the increasing separation of nurses, particularly the most highly trained nurses of the profession, from patient caretaking.

The Committee was aware of a number of relatively small scale demonstrations, applying this concept in various parts of the United States 1, 2 and of its application as fairly standard practice in many other developed countries of the world.3 However, it had no knowledge about the depth and extent of opinion of Academy membership on this subject. Furthermore, it soon came to realize that there is virtually no information available concerning the distri-

bution of task performances in the private practice of medicine.

In order to plan and develop a program, the Committee designed and mailed out a detailed questionnaire in late 1967 and early 1968 to all regular Fellows of the Academy of Pediatrics. This effort was funded by a special grant from the Maternal and Child Health Service of the Department of Health, Education and Welfare. A response rate of 90% was achieved. The final results were

published in 1970.4

From the work load data of the survey, it was estimated that if an allied health worker were to assume an expanded patient-care load only for health supervision, a minimum of 25% of the pediatrician's time would be freed. If other activities of the pediatrician (clerical, technical, and laboratory tasks plus some aspects of illness care) were taken into consideration as well, it seemed probable that at least 50% of the average practitioner's time would be freed.

The returns further revealed that many nurses working in pediatricians' offices are performing tasks and duties which do not require nursing training or skills. Relatively few nurses were being utilized by pediatricians in true interprofessional caretaking, a finding in sharp contrast to expressed pediatric opinion which clearly favored such a movement. Although these findings were not unanticipated, they made it clear that the potential for wider spread of

the pediatrician's and the nurse's skills did indeed exist.

Given this mandate by the membership, the Executive Board of the Academy in 1969 adopted an official policy statement that a physician may delegate to a properly trained individual working under his supervision the responsibility of providing appropriate portions of health examinations and health care for infants and children.⁵ In effect, the Academy recognized the delegation of tasks as usual and customary practice in pediatrics. Additionally, in late 1969 the Office of Allied Health Manpower was authorized and established at

Academy headquarters.

The Committee on Manpower also established a close working relationship with the American Nurses' Association which was equally concerned about the number of American children receiving less than adequate care and about the fact that nursing potential was not being fully utilized to deliver ambulatory health care to them. The joint statement of the American Nurses' Association and American Academy of Pediatricians, published in this issue, places both of these professional organizations squarely behind the concept of task sharing under contracted conditions.6 It is a significant accomplishment and a major step in reorienting the delivery of health care to children in this country. Recognizing the urgency of the current situation and the need to act rapidly, the statement includes a set of training guidelines for the establishment and operation of continuing education programs for nurses which in themselves require joint rather than unilateral action.

Although a major step has been taken by the development and approval of this statement, both groups recognize that it is only a first step toward widespread application of task sharing and collaborative care. If the nurse is to act in an expanded role, someone must perform the nonnursing tasks which she is now discharging. Furthermore, both she and the pediatrician must be educated to new roles and become accustomed to playing them. In the short run, this implies the rapid development of continuing education courses sponsored jointly by pediatric and nursing groups. Tested models for such courses already exist.* In the long run, however, basic nursing and medical education must be changed to accommodate to the concept of interprofessional care.

JOHN P. CONNELLY, M.D., Chairman, Committee on Manpower, 1965-70, Executive Director, Bunker Hill Health Center of the Massachusetts General Hospital.

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5. American Academy of Pediatrics Newsletter. 20:1969.

6. Guidelines on Short-Term Continuing Education Programs for Pediatric Nurse Associates, Pediatrics, 47:1075, 1971.

A JOINT STATEMENT OF THE AMERICAN NURSES' ASSOCIATION, DIVISION ON MATERNAL AND CHILD HEALTH NURSING PRACTICE, AND THE AMERICAN ACAD-EMY OF PEDIATRICS—GUIDELINES ON SHORT-TERM CONTINUING EDUCATION PROGRAMS FOR PEDIATRIC NURSE ASSOCIATES

I. INTRODUCTION

The American Nurses' Association and American Academy of Pediatrics recognize collaborative efforts are essential to increase the quality, availability, and accessibility of child health care in the U.S.A. In order to meet the health care needs of children, it is essential that the skills inherent in the nursing and medical professions be utilized more efficiently in the delivery of child health care.

Innovative methods are needed to utilize these professional skills more fully. One such innovative approach is the development of the Pediatric Nurse Associate** program. This program will enable nurses, both in practice and reentering practice, to update and expand their knowledge and skills. It is essential that physicians become more aware of the skills and abilities of the nursing profession and that such skills be expanded in the area of ambulatory child health to enable both the nurse and the physician to devote their efforts in the delivery of child health care to the areas of their respective professional expertise.

The expansion of the nurse's responsibilities would encompass some of the areas that have traditionally been performed by physicians. Proficiency and competence in performing these new technical skills associated with the expanded responsibility should be viewed as increasing the sources from which the nurse gathers data for making nursing assessment as a basis for diagnoses and action and thus contributing directly to comprehensive nursing. Nurses

interchangeably.

^{*}For further information write the office of Allied Health Manpower, American Academy of Pediatrics, Box 1034, Evanston, Illinois 60204.
**The titles "Pediatric Nurse Associate" and "Pediatric Nurse Practitioner" are used

must therefore be prepared to accept responsibility and accountability for the performance of these acts and must have the opportunity to be engaged in independent as well as cooperative decision making.

The ANA and AAP are agreed in developing the following guidelines and concepts for short-term continuing education courses for Pediatric Nurse

Associates (PNA).

II. FUNCTIONS AND RESPONSIBILITIES

As nursing functions have changed over the years, and nurses have assumed responsibilities that have formerly been performed by physicians, the two professions have issued joint statements concerning the changes. The continuing discussions between the American Nurses' Association and the American Academy of Pediatrics concerning the preparation of nurses for pediatric ambulatory nursing practice represents a formalized joint effort of both professions to collaborate and plan for the reorganization of certain health care services to children.

The following responsibilities in ambulatory child health care include those

which are inherent in existing nursing practice:

Secure a health history.

Perform comprehensive pediatric appraisal, including physical assessment and developmental evaluation on children from birth through adolescence.

Record findings of physical and developmental assessment in a systematic

and accurate form.

Advise and counsel parents concerning problems related to child rearing, growth, and development.

Advise and counsel youth concerning mental and physical health.

Provide parents and other family members with the opportunity to increase their knowledge of the skills necessary for maintenance or improvement of their health.

Cooperate with other professionals and agencies involved in providing services to a child or his family and when appropriate, coordinate the health

care given.

Identify resources available within the community to help children and their families, and guide parents in their use.

Identify and help in the management of technologic, economic, and social influences affecting child health.

Plan and implement routine immunizations.

Prescribe selected medications according to standing orders.

Assess and manage common illnesses and accidents of children.

Work collaboratively with physicians and other members of the health team in planning to meet the health needs of pediatric patients.

Engage in role redefinition with other members of the health team. Delegate appropriate health care tasks to nonprofessional personnel.

III, CONTINUING EDUCATION PROGRAMS

A. Goals

The goal of continuing education programs for preparation of Pediatric Nurse Practitioners is to provide knowledge, understanding, and skills that will enable them to assume a direct and responsible professional role in ambulatory child health care. The programs should build on previous nursing knowledge and skill and include some knowledge and skills that conventionally have been the province of the physician. Experimentation is indicated as the health professions attempt to change their functions.

On completion of the program, the Pediatric Nurse Associate should be

able to:

Secure a child's health and developmental history from his or her parent and record findings in a systematic, accurate, and succinct form.

Be able to evaluate a health history critically.

Perform a basic pediatric physical assessment using techniques of observation, inspection, auscultation, palpation, and precussion and make use of such instruments as the otoscope and stethoscope.

Discriminate between normal variations of child development and abnormal deviations by utilizing specific developmental screening tests and refer children

with abnormal findings to the pediatrician.

Discriminate between normal variations of child development and abnormal physical assessment and know when to refer the child to the physician for evaluation or supervision.

Provide anticipatory guidance to parents concerning problems of child rearing, such as: feeding, developmental crises, common illnesses, and accidents.

Recognize and manage specific minor common childhood conditions. Carry out (and) or modify a predetermined immunization plan. Identify community health resources and guide parents in their use.

Make home visits in view of presenting health problems.

Make decisions arrived at prospectively and collaboratively with the physician, in addition to decisions involving a level of traditional nursing judgments. Trust and a close state of interdependence are essential for this collaborative decision making.

B. Planning

Collaboration between nursing and medicine is vital in achieving understanding of the preparation of Pediatric Nurse Associates. In order to ensure such collaboration, it is necessary that nursing and medicine assume equal responsibility for planning the Pediatric Nurse Associate short-term continu-

ing education programs.

Planning should take into account national, regional, and local needs for ambulatory child health care. Planning should involve district and state nurses' associations, district or chapter chairmen of the AAP, and nursing and medical schools. Active participation should be sought from consumer groups, since their orientation to the changing roles of physicians and nurses will determine to a significant extent the effective utilization of these professionals.

C. Organization and administration

Every attempt should be made to establish the educational programs to prepare Pediatric Nurse Practitioners under the aegis of accredited collegiate nursing programs. Whenever possible the program should be developed in collaboration with a Department of Pediatrics of a College of Medicine. Programs should conform to the existing policies and regulations governing the conduct of comparable educational programs. As in the delivery of care, the organization and implementation of the educational program should be a joint pediatric and nursing effort. The educational programs should be financed as are other continuing education programs sponsored by the institution. A variety of funding sources may be included.

D. Services and facilities

The program should provide:

A health service for evaluation and maintenance of mental and physical health of the students.

A counseling service for student guidance.

Library facilities which contain an adequate supply of books, periodicals, and other reference materials related to the curriculum.

Appropriate teaching aids and classroom facilities.

Clinical facilities for demonstration, student observation, and directed practice experience in public and private ambulatory and applicable inpatient settings. These facilities should be in institutions, clinics, or private offices which have sufficient qualified, experienced child care personnel, and adequate numbers of patients to provide the type and amount of experience for which the student is assigned.

E. Faculty

Collaboration between nursing and medicine is vital in achieving the goals of the program. For this reason, the planning and implementation of the curriculum should be a joint effort of both professional groups.

The medical and nursing codirectors of the program should be qualified.

The medical and nursing codirectors of the program should be qualified through both academic preparation and experience as practitioners. The faculty should meet the same requirements as other faculty of the sponsoring insti-

tution.

Medical input will be primarily in those areas of health care that have traditionally been within the province of medicine. Since the acquisition of new knowledge and skills is intended to enhance professional nursing practice, appropriate nursing faculty should assume major responsibility for the development and implementation of the program.

It is envisioned that wherever appropriate, other members of the health team, for example, psychologists, nutritionists, and social workers, would participate in teaching in order to assist students in gaining perspective of the interdependent role and contributions of other health professionals. The nursing codirector of each program is also the logical person responsible for the coordination of the educational input of these other health professionals.

Other instructional staff should be qualified through academic preparation

and experience to teach the subject (or subjects) assigned.

The student-instructional staff ratio should be in at least the same proportion as similar education programs organized by the sponsoring institution.

Joint appointments for faculty between departments of pediatrics and the schools of nursing are recommended.

F. Course content

Curriculum should build on existing nursing knowledge and skills, updating and adding depth in the areas of normal growth and development, clinical pediatrics, and the behavioral sciences. It should provide a systematic program to increase the nurse's ability to make a more discriminative and accurate assessment of the developing child.

Growth and Development

A comprehensive review of growth and development and normal variations, including the use of the Denver Developmental Screening Test, or a comparable instrument.

Interviewing and Counseling

Principles of the interviewing process and basic approaches to counseling parents in child-rearing practices.

Family Dynamics

Study of attitudes and knowledge needed to identify factors that affect interaction between family members and critical periods in family life. Review of sociocultural patterns and their influence on family health.

Postive Health Maintenance

Basic child care, including physical assessment, nutrition, immunization programs, safety and accident prevention, dental health measures, and other aspects of anticipatory guidance.

Childhood Illness

Review of systems and the most commonly seen pediatric illnesses, with emphasis on prevention, management, early recognition of complications, and the more common emotional adjustment problems of each age group; importance of health education for families in providing better health care in the home.

Community Resources and Delivery of Child Health Care Services

Review of community resources, traditional modes of delivery of services, the referral process, and new patterns of providing comprehensive health care.

Family/Nurse/Physician Relationship

Interpret goals of the nurse/physician team and role changes required for practicing in an expanded role. Review elements of working within a system while changing the system.

Clinical Experience

Planned field experiences and directed practice which provide a transition from theory to application should be incorporated into the program. These activities should allow for the application of previous and ongoing learning under the direction of competent instructors and practitioners. There should be qualified preceptors in each field of practice to which students are assigned under the general direction of the directors of the program.

G. Admission of students

Only registered nurses are eligible for the programs. Policies for selection of students should be developed by the faculty of the sponsoring institution in cooperation with those responsible for conducting the programs. Admission criteria should be based on education and experiential factors, taking into account local needs and resources. Careful assessment of each applicant's qualifications is indicated, to assure that those admitted have a common core of knowledge and skill. If the applicant lacks preparation in an area regarded as essential, he or she should be guided to correct the deficit before entering the program, or to enroll in a supplemental course concurrent with enrollment in the Pediatric Nurse Associate program. Pretesting for admission and appropriate placement appears advisable in the following areas: knowledge of growth and development of children; care of children with common health problems; child psychology; and family dynamics.

Because a larger purpose of this course is to change the current delivery practices of pediatric health care by placing in action working models of "pediatric team" care, it is recommended that the trainee already hold a job within a practice setting that serves as a source of comprehensive health care for all children in a family. It is recommended that each nurse accepted as a trainee be guaranteed by her employer the opportunity to function in an

expanded role in the practice setting in which she works.

Adoption of this expanded role by the nurse makes it necessary for her to relinquish responsibility within her work setting for nonpatient care tasks of an indirect and clerical nature. These tasks can be assumed by trained assistants, aids, and secretaries.

H. Length of program

Experience to date has indicated that a minimum of 4 months of educational

experience is needed to attain the desired objectives.

The program should include a combination of classroom work, clinical practice and work experience composed by approximately 4 hours of class and 8 to 12 hours of supervised clinical practice each week, with the remainder devoted to on-the-job work experience.

I. Evaluation

Special licensing or accrediting of programs or certification of individuals who complete the programs would be premature at this stage. Opportunity for experimentation in educational programs and in manpower utilization is essential for full exploration of ways to improve health services. The candidate who successfully completes the program should be provided with a certificate of completion, or other written statements, according to the policies of the educational institution under whose aegis the training was conducted.

It is imperative that the educational, attitudinal, and economic aspects of the continuing educational programs for the Pediatric Nurse Associate be evaluated within each program. The data collected from ongoing evaluation can be utilized to modify the upgrade existing programs in the area of pre-

requisites, curriculum, facilities, and faculty.

Each program should conduct ongoing evaluation of graduates to include:

Adequacy of care rendered.

Acceptance of expanded role by self, pediatrician and recipients of care. Productivity measures and cost effectiveness analysis.

APRIL 6, 1977.

DEAR SENATOR CLARK: I am a University of Rochester nursing student and I am writing in regard to a bill (S. 708) which would permit Medicare reimbursement to rural health clinics which provide primary health care.

All of the students in my class that I have approached on the topic are very much in favor of this bill. We feel that with its passage there would be increased career mobility and so increased availability of health services for the rural citizen.

With the coming trend of the "health care extender", which will provide services at reduced cost it seems obvious that those in this profession need reimbursement to make the occupation feasible.

Sincerely,

PHYSICIAN'S ASSISTANT PROGRAM. UNIVERSITY OF IOWA, Iowa City, Iowa, April 15, 1977.

Senator DICK CLARK. Russell Senate Office Bldg., Washington, D.C.

DEAR SENATOR CLARK: I would like to make some comments concerning the Senate Bill 708 which has been introduced by you and Senator Leahy.

In my estimation the legislation in its current form will have little impact on the majority of physician's assistants. Please find below a modification which I am recommending: (a) The bills by the House (H.R. 2504) and Senate (S. 708) should be expanded so that reimbursement for PA services may be obtained by rural physician practices and urban physician practices not just rural clinics.

I firmly believe that services rendered by physician assistants should be reimbursed. I also support the notion of physician supervisor of physician's extender activities but it need not be continuous, over-the-shoulder supervision.

The argument that 3rd party reimbursement for PA services is inflationary is not supported by fact. The very significant increase in the provision of quality medical care by PAs far outweighs any potential small increment in costs.

In summary, I very rigorously support the adoption of legislation permitting reimbursement of physician's extender services and I think that if the H.R. 2504 and S. 708 bills are amended as discussed above a significant achievement will have been made.

Sincerely,

DENIS R. OLIVER, Ph. D., Director.

DEAR SENATOR CLARK: Hooray for this bill! It has been needed for a long time. I watched my parents haul an elderly couple to the doctor; the trip was painful and long for them. I watched as they had to sit and wait a long time for a too busy doctor, I watched the elderly lady break down and cry from all she had to go through to receive medical treatment and I watched them worry about the bill. Too little transportation, too long a ride, too busy a doctor, too much money.

Your bill provides an alternative: A high quality care clinic, supervised by physicians, staffed with state certified competent medical personnel, nearby, well-equipped, covered by medicare and protected from money wasting and mis-

use.

Sincerely,

RANDALENE A. SAUER. JERRY D. SAUER.

MARCH 18, 1977.

Senator DICK CLARK, Washington, D.C.

DEAR DICK: I've been a member of our fine county health planning council and now am on the board of our 2 county sub-area unit of the Iowa Health

Service Agency.

We are hesitant to enter the areas of the unconventional because we are practitioner dominated. I'm getting awfully tired of 1122 reviews dedicated to perpetuating the community hospital concept so they can attract and hold physicians. 62% as an acceptable occupancy rate is unacceptable to me. I'm also tired of dividing up the pie of nursing care between various nursing home chains because there is no adequate home health service system.

I heartily approve of your Rural Health Clinic Bill to allow the use of medicare funds for small rural health clinics that use physician extenders to pro-

vide primary care.

The Gundusen Clinic of La Cune, Wisconsin has already opened two branches, one in Onalasha. Wis. and the other in Spring Grove, Wis. These are iointly community clinic staffed.

I think those of us who have suffered from an incorrect diagnosis are especially alert to the vertical concept of health care which would probably necessitate the use of specialists if indicated instead of holding on to their own patients too long.

From my involvement in rural living I can see the health clinic being a vital component of a Public Service Center located in our expanding rural

communities.

There are other areas of the Health Care System I would also like to see

addressed.

A. Getting away from the concept each community needs to build and maintain a hospital as the local laboratory for doctors in order to attract and hold them in a community. Adequate Emergency Medical Transportation, prompt referral, home delivery of babies, (except high risks), computer links with major resources such as our Mayo Clinic and Gundusan Clinic.

B. The nursing home phenomena is a reflection of our lack of health services for the sick and elderly. Relatives are prohibited from receiving any kind of support for caring for their sick and elderly in their homes even though it may be at only a portion of the nursing home cost. Actually, except for short term care it is rather a barbarian custom just one small step removed from euthanasia.

C. We spend billions for remediation but a pitiful amount for prevention. In Iowa, except probably in a few instances, there is no decent health curriculum in our public schools, although written into the law it is consistently

Instruction, correction and maintenance are even more important—birth to school age.

Consumer education, air, water, and food pollution need to be eliminated. Keep up the good work Dick, you have already left giant footprints.

Sincerely.

SARA SMERUD, New Allen, Iowa.

MARCH 22, 1977.

DEAR DICK: I note your hearing in regard to Rural Health Clinic Services. I think it a marvelous idea, providing it can be made possible and get the co-operation of the Medical Association. In our case in Winneshiek County—

population about 21000 with about 8 M.D.'s and one surgeon.

Decorah has 6 M.D.'s, one surgeon and a 100 bed County Hospital is surrounded by several small communities. Colmar, one M.D. (who lives in Colmar), Ossean, one M.D. (part time who lives in Decorah, office in Ossean), Ridgeway, none; Burroak, none; Freeport, none; Feslina, none; Frankville, none; all communities, 300 up to 1200. If they have no M.D.'s, they have no dentists. The whole county is short of dentists. If medical assistants and superior nurses were authorized, the Decorah M.D.'s could give some superior nurses were authorized, the Decorah M.D.'s could give some superiors. vision under the proper regulations, especially if the local Clinic could get proper financing. They could build a building to take care of ten or 12 M.D.'s instead of four. With a Modern County Hospital, which has close connections with the Mayo Clinic in Rochester. An opthamologist will locate here in August—on his own. We need him, especially me—who has bad cataracts.

I rather think other counties in Iowa are typical of Wenneshiek, except where the County Seat is occupied by larger cities, such as Des Moines, Cedar Rapids, Waterloo, Mashaltown, Ottumiba, and Sioux City, etc. Allamakes is short of M.D.s, although they got two more young M.D.s recently, who turned down Decorah because they felt the Medical Association were too tough on

competition.

I think your idea is a marvelous idea but I'm afraid it will be difficult one to work out successfully. We have no M.O.s, the M.D.s haven't quite accepted them as yet. But we could use a couple.

Don't know if this has been of any help, anyway we wish you success.

Sincerely,

CHARLES ALTFILLISCH, F.A.I.A., Decorah, Iowa.

FALLS CHURCH, VA., March 23, 1977.

Hon. Dick Clark, Chairman, Rural Development Subcommittee, Committee on Agriculture and Forestry, U.S. Senate, Russell Bldg., Washington, D.C. (Attention Mr. David Hart).

Dear Senator Clark: I appreciate the invitation to submit testimony for the hearing, on March 29, on S. 708, a bill to permit Medicare Reimbursement to rural health clinics for primary health services. You probably learned of my interest in this subject from my testimony in the record of the Hearings by Subcommittee on Health of the Finance Committee, on S. 3205, a bill for reform of Medicare-Medicaid administrative and reimbursement procedures, in July 1976. (pages 523-528 of those Hearings). I particularly welcome your invitation because, as an employee of the Social Security Administration, while the Medicare program was in gestation there, I was instructed that it was "inconsistent with acceptable conduct for an employee of the Social Security Administration to write to members of Congress, officials in the Executive Branch or newspapers" giving independent views on "matters affecting programs of the Department," and I was forbidden to attend Congressional hearings dealing with such matters, "even on annual leave, without supervisory approval." (Memorandum to me, August 20, 1964).

In my files, quite by coincidence, I just found a copy of a letter I wrote to Senator Russell B. Long, now Chairman of the Finance Committee, in which I complained that "there was no economic analysis, as distinguished from statistical description of history or from actuarial projection" in the preparation for the Medicare program," and I asked "who is studying health economics in the Government?" (My letter to Senator Russell B. Long, Aug. 15, 1964). The Report of the Advisory Council on Social Security, 1965, which guided Congress in setting up Medicare, was buttressed by an actuarial report in the Appendix but there was no economic discussion in it. Just before, Medicare was passed in the Senate, Sen. Long said that it could be "better judged by an economist than an actuary, better by a social worker than an accountant . . ." (CONGRESSIONAL RECORD, July 9, 1965, page 15582.)

The 1971 Report of the Advisory Council on Social Security showed a slight improvement over the 1965 Report, but it still had the actuarial fixation, although a couple of economists contributed to it. According to Dorrance Bronson's Concepts of Actuarial Soundness in Pension Plans (1957), "actuarial soundness is not a clearly defined concept. I have seen no other book even rasing the question. I have not seen the 1976 Report of the Advisory Council on Social Security but what I've seen about it seems to indicate that Senator Long's preference for an economist and social worker over an actuary or accountant in judging the Medicare program has not convinced or influenced the Social Security Advisors of Congress. Senator Abraham Ribicoff's Feb. 17, 1967 strictures about Congressional "abdication of responsibility" and

absence of "independent judgment" are still relevant.

In my testimony in the Hearings on S. 3205 on Medicare-Medicaid Administrative and Reimbursement Reform, in July 1976, I raised a question which is relevant to your Hearings on Reimbursement of Rural Health Clinics. Dr. Kermit Gordon was appointed the first Chairman of the Health Insurance Benefits Advisory Council, early in 1966. This Council was to guide the health insurance programs, and no longer an employee of the Government, I questioned its Chairman at a public meeting. My dialogue with Dr. Gordon appears on pages 526-527 of the Hearings on S. 3205. I asked "whether up to now the economist hasn't been completely crowded out. . . The Budget Bureau informs me that they intend to classify Medicare payments for hospitals and other medical services as transfer payments, not as purchases (by the Government) of goods and services. It seems to me that if you were only concerned with costs to funds, but not to people, this would be O.K. But when you consider, as an economist, real costs to real people, you have to consider that now for the first time Social Security money is going to be spent for the beneficiaries and not by them. Don't we delay coming to grips with the economic problem of getting the most from limited resources by classifying this as 'transfer payment' rather than purchase of goods and services?" Dr. Gordon assured me that his being Chairman of the Health Insurance Benefits Advisory Council meant that "the economists have at least a foot in the door."

Later I got the same answer from a Social Security official who had to answer me because a letter I wrote to President Johnson came to him for reply. Stop worrying, he said, and reminded me that Dr. Kermit Gordon was on the job.

The second Chairman of the Health Insurance Benefits Advisory Council was Dr. Charles L. Schultze who had been a very capable Director of the Bureau of the Budget, as Dr. Gordon had also been before him. Today Dr. Schultze is the Chairman of the President's Council of Economic Advisors.

Three paragraphs from a letter I wrote him are as follows:

"Mr. Arthur E. Hess, Director of the Bureau of Health Insurance (of the Social Security Administration), which will administer the Medicare program, says that "the public will generally react to Medicare as a total program... He (the beneficiary) is a subscriber of the total health insurance program... his program relationship must basically focus on the Social

Security Administration.'

"A new dimension will be introduced into the expenditure of Social Security funds. Till now the Secretary of the Treasury concerned himself with the investment side and the Secretary of Health, Education, and Welfare with the transfer payments to the beneficiaries. (The Secretary of Labor had nothing to do, though also one of the trustees.) Who will give an accounting to me (a private citizen) on how well the job of purchasing goods and services to promote health and cure sickness is done?

"The Social Security Administration has refused to respond to my questions as an employee with an assignment in this field and now as a private citizen I would appreciate your cooperation in getting the answers." (My letter to

Dr. Charles L. Schultze, May 31, 1966)

Dr. Schultze did not respond nor cooperate with me trying to get the answers, although I had appealed to principles he had preached when spelling out the Programming-Planning-Budgeting System (PPBS) initiated by Pres. Johnson in Aug. 1975 to all Government departments, with the apparent exception of the Social Security Administration, which sits on the Social Security Trust Funds (moneybags?). (How does PPBS compare with "zero-base

budgeting", now in vogue?)

In 1970, I heard Dr. Charles L. Schultze at a luncheon of the National Economists Club say that it was generally thought "that you ought to have your head examined," if you suggested when Medicare and Medicaid were started that they should be examined in terms of economic priorities. That meant, among a few others, Dr. Schultze, Senator Russell Long and me, while I was in the Social Security Administration. The only suggestions for study in the 1965 Reports of the Ways and Means Committee and of the Finance Committee on the Social Security Amendments then under way had nothing to do with health economics, except by way of survey sampling and "actuarial" reporting. Great parts of these alleged Congressional reports were prepared by Social Security Administration personnel, and in late 1964 there was a task force preparing the groundwork in the Division of Disability Operations with no economist on it. I was there, too, but they told me to have my head examined.

They came up with a "reasonable cost" concept about which everybody, starting with the Gorham Report on Medical Care Prices, in 1967, addressed to President Johnson, found that it prevented true "program evaluation" and "cost reduction" as envisaged in the PPBS program, or genuine economy in the use of health resources. Before the Subcommittee on Executive Reorganization of the Senate Government Operations Committee, chaired by Senator Abraham Ribicoff, to whom I wrote a letter, printed at the end of their hearings, a report on "Health Care in America", H.E.W. Secretary Wilber J. Cohen testified that they were still waiting for a "good idea, a workable idea on incentive, efficiency and economy", after which they would come to Congress to give them "some kind of authority" to make a beginning in the direction of studying health economics. This was in 1967 when in June Secretary Cohen's predecessor as H.E.W. Secretary John W. Gardner had already called a National Conference on Medical Costs whose report had some good ideas.

The bill which you propose "would change an existing Medicare regulation that prohibits reimbursement to clinics that lack full-time physicians. It would allow the use of Medicare funds for small, rural health clinics that use physician extenders to provide primary care and treatment to citizens who gen-

erally lack other sources of basic health care." Now the controversy which I

have been discussing is related to your present proposal.

The mere fact that the Rural Development Subcommittee of the Senate Committee on Agriculture, Nutrition, and Forestry enters the picture of the Medicare program, previously considered in the exclusive bailiwick of the Finance Committee (and the Ways and Means Committee on the House side) is significant. Logically, the Finance Committee deals with Government revenue and it is something of a hybrid to deal also with Government expenditure of funds properly appropriated for an ear-marked program. The Government is better at collecting money than at spending it. Before Medicare, the Government did not have to spend on goods and services funds which the beneficiaries did for themselves in the Social Security System. I object to a classification in the Commerce Department national income accounts the logic of which is that Medicare spending is no different than that for case benefits for old-age pensions. According to the Commerce Department (Survey of Current Business, August 1966, page 7) "the individual, rather than the Government, is the actual purchaser of medical services" in the Medicare program. Mr. Arthur E. Hess, formerly my chief, in the Social Security Administration, said correctly that this is not so, but, as I have quoted above, that the public will generally react to Medicare as a total program . . . and a subscriber (has) a program relationship" whereby the Government purchases in his behalf. At all times in testimony before Congress, Social Security representatives, correctly, made a sharp distinction between "cash payments" and "health insurance payments". Yet they have acceded to the Commerce Department classification which blurs this distinction. They did this, they wrote me, because a majority of experts on a certain committee agreed to it, and wouldn't discuss the economic merits or demerits of that decision. This was not a question of professional economics, but of bureaucratic discipline.

Formerly, the Social Security beneficiary could spend his pension check any way he pleased, even on health, with no accounting to anybody else. But now that his Social Security money is spent for him by public agencies, there must be the same public accounting as for the use of other Government funds.

In my testimony on S. 3205, a bill for Medicare-Medicaid Administrative and Reimbursement Reform, I quoted from the July 30, 1976 Washington Star, Rep. Charles A. Vanik's opinion that Congress should not give the Social Security Administration any more new social programs. An interesting question is why did Congress without adequate economic study give the Medicare program to that agency? With "zero-base budgeting" now in the air, this is not just an historical question. Is health only of concern to those retired from work, for whose cash benefit the Social Security System was set up? S. 3205 proposes setting up a new agency in the H.E.W. "a single Administration for Health Care Financing." What is "health care financing"? What is its relationship to health?

As a result of President Johnson's August, 1965 Executive Order for the introduction of Programming-Planning-Budgeting, H.E.W. Secretary John W. Gardner convened a National Conference on Medical Costs (June 27–28, 1967) which issued a Report, containing a symposium of papers. One of the best was that by Dr. Victor R. Fuchs, then Associate Director of Research, National Bureau of Economic Research, "The Basic Forces Influencing Costs of Medical Care," (pp. 16-31.) He said: "Some of us, when visiting hospitals, have discovered that by putting on a white coat and talking rudely to nurses, it is easy to pass as a physician." it is easy to pass as a physician. To be mistaken for an economist is often

even simpler. All one need do is say 'demand and supply'".

How will President Carter's reputed interest in "zero-base budgeting" be translated to the health field? It seems to imply considering every Government program as if it is just being created. That is the Medicare and Medicaid programs would have to be reconsidered. The separation of health of the aged from health of the rest of the population, as implied by the Medicare program, should be reconsidered, after, not before, the relevant health economics has been studied.

The same Dr. Vincent R. Fuchs wrote a book, Who Shall Live? Health, Economics and Social Choice, (1974), which provides a good beginning for the economic study which should precede any health or health insurance program

which can be satisfactory. The proposed S. 708, a bill to permit Medicare Reimbursement to rural health clinics for primary health services that lack full-time physicians, raises issues which Dr. Fuchs discusses in Chapter 3, "The Physician: The Captain of the Team." (pages 56-78).

The same physician who speaks "rudely to nurses" treats patients tenderly. The philosophy behind S. 708 is that the required tender treatment conducive to health comes in large part from "physician extenders," and Dr. Fuchs shows that often this is conducive to better economy and more accessible health care. He quotes from a letter from a physician to Medical Economics (page 64): "Fully 80 percent of illness is functional, and can be effectively treated by any talented healer who displays warmth, interest and compassion regardless of whether he has finished grammar school. Another 10 percent of illness is wholly incurable. That leaves only 10 percent in which scientific medicine—at considerable cost-has any value at all.

According to Dr. Fuchs, the availability of large numbers of physicians extenders offers the promise of simultaneously lowering the cost of (health) care, improving access, and possibly even raising health levels. . . . Many physician extenders can relate more closely to patients and their problems, communicate better with them, and afford to spend more time with individual

patients." (page 75).

I would support S. 708, a bill to permit payment of Medicare funds to rural health clinics without full time physicians, at the same time urging reconsideration of the undesirable separation of the Medicare program from a general health insurance program.

SIDNEY KORETZ, Economic Consultant.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, SOCIAL SECURITY ADMINISTRATION, OFFICE OF CHIEF ACTUARY, Baltimore, Md., March 21, 1977.

Hon. SENATOR CLARK, U.S. Senate. Committee on Agriculture and Forestry,

Washington, D.C. DEAR SENATOR CLARK: Attached is a table showing the cost estimates for S. 708 and the administration proposal for Medicare reimbursement of health

clinics.

The Administration's proposals differs from S. 708 primarily in the number of areas that would be eligible to have a reimbursable clinic. We have assumed that under S. 708, 500 clinics would initially be covered and by 1982 there would be 950 covered clinics. Under the Administration's bill, we have assumed 725 clinics would be covered initially and 1945 by 1982. We have assumed that the initial cost per clinic would be \$220,000; this is adjusted for the proportion of use by medicare beneficiaries, copayment, and administrative expenses to arrive at the enclosed estimates.

If we could be of further assistance, please let us know.

Sincerely,

CHUCK SARKISIAN.

Enclosure.

COST ESTIMATES FOR HEALTH CLINICS EMPLOYING PHYSICIAN EXTENDERS

[Dollars in millions]

Fiscal year	Senate bill 708	Administration's proposal
78	\$20	\$25
79	35	50
0	45	65
81	50	80
82	60	115

CHAPEL HILL, N.C., March 16, 1977.

Senator Dick Clark, Senate Rural Development Subcommittee, Russell Bldg., Washington, D.C.

(Attention Dave Harf).

Dear Senator Clark: In response to your request, I am pleased to provide written testimony concerning S. 708, a bill which would permit Medicare reimbursement to rural health clinics, thereby compensating the costs of pro-

viding services by physician extenders.

I am particularly gratified that this bill has been introduced. The Rural Practice Project is a national grants program of The Robert Wood Johnson Foundation which assists in underwriting some of the startup costs for new community practice models in underserved rural areas. As Secretary Califano noted in his report to President Carter, "American Families: Trends, Pressures, and Recommendations," the practice models of the Rural Practice Project do indeed fact financial problems because of the current Medicare extender policy.

In the Rural Practice Project's guidelines bulletin appears the following statement: "These service needs of patients are to be provided for by a practice team of physicians and intermediate-level practitioners (physician's assistants or nurse practitioners). Intermediate-level practitioners should practice in a ratio of at least one for each full-time physician." The rationale for this guideline is a very simple one: in areas of the Nation where physician manpower is scarce, its productivity ought to be maximized. Yet the restrictions in Title 18 of the Social Security Act make it difficult for such improvement in productivity to be realized by a practice and still survive financially. Therefore, the rural health clinic bill can provide important assistance for these

kinds of community-oriented rural practices.

I am particularly gratified to note that payment would be made to the "clinic" rather than to an individual, and that the basis for payment would be reasonable costs and not "customary fees." In this era of concern over the excessive rate of inflation for medical care, this provision is especially appropriate. It would also permit valuation of a clinic's services. (The fact is that some clinics do far more for the patient than others. Their services may, therefore, cost more, but they are worth more, too. I would hope that, should this bill be enacted, the Secretary might adopt a test of reasonableness of cost that could account for these differentials in value, instead of assuming that the fee charged is automatically representative of the value of the service provided, which is what the reimbursement policy under Medicare does now.)

In this regard, I would suggest that one additional criterion be included under the definition of the term, "rural health clinic." This is that (the facility) maintain appropriate accounting procedures for costs and income. This, it seems to me, would be essential to a method of payment based on the "reasonable costs of providing the service" as well as for any subsequent comparison

between costs and value.

Thank you for the opportunity of making this comment. If I can be of further assistance, I would be happy to do so.

Sincerely,

DONALD L. MADISON, M.D.

STATEMENT OF HUGH S. COLLETT, M.D., ELKO CLINIC, ELKO, NEV.

There is a lot of planning for rural health care mainly by people who do not live or practice medicine in rural areas. Rural areas have different needs based on the wealth of the people, the transportation available, and the sophistication of their medical knowledge. A rural health program for uneducated, poor people in a community with poor or nonexistent transportation is entirely different from that needed by people in a rural area who are well educated, financially able to provide for themselves, and who have a superhighway available to a nearby medical center. There is a misconception that the medical need in rural areas is coverage; therefore, the proposed solution is a governmentally financed nurse practitioner or Medex. They contend that the diagnosis and treatment of disease by these inadequately trained people is desirable for improving rural health. They also believe that these para-

medical personnel can be supervised by periodic evaluation of charts by visiting physicians who never see the patient. The medical needs for rural citizens are the same as for urban citizens; it is quality medical care, not "coverage". Quality care can be achieved only by medical care from a qualified physician examining and treating the patient himself, not by listening or reading secondhand the findings of an inadequately trained paramedical person. It is doubtful if professors in medical centers would produce these people to work independently in rural areas if they also expected them to practice medicine independently one block from the school where they were taught. Transportation is required to bring the rural patient to quality medical care (if the government wishes to subsidize rural health, it should consider subsidizing specialized comfortable surface or air transportation to bring the patient to the doctor for evaluation and treatment. Ambulances are generally available for emergencies or accidents, but routine care requires a different type of transportation). These quality medical facilities need all of the population and all of the medical dollars available in the community in order to have the medical and financial stability to develop and survive. The multi-specialty clinic, in a central rural base area with good transportation and no competition from government-financed "coverage", is the desirable approach to rural health care.

> Asociación Politica de Habla/Apellido Español, Spanish Speaking/Surnamed Political Association, Inc., San Francisco, Calif., March 15, 1977.

Re Senate bill 708—Rural Health Clinic bill for inclusion in the record.

Mr. DAVID HARF,

To The Honorable Chairman, Senate Rural Development Subcommittee, Dick Clark, Esq., Russell Bldg., Washington, D.C.

Dear Chairman Clark and Members of the Subcommittee: On behalf of Spanish speaking/surnamed taxpayers, veterans, citizens and legal residents, we favor the elimination of discrimination against Spanish speaking and other non-English speaking persons whose health care needs are not being met because of English-only approaches to health care and the present lack of Medicare

reimbursement to rural health clinics for primary Health Services.

In addition, it is vital that the stop-gap measure which will permit Medicare coverage for health services provided by nurse practitioners and physician's assistants be supplemented by an incentive program to induce physicians to dedicate a part of their time, at least, to the delivery of health services to persons in rural areas, either with the direct use of non-English language diagnostic abilities or with the help of persons certified to be knowledgable in both the language of the patient and that of the physician or nurse or other health care person.

In response to your question, given assumption of the above, I would say:

1. Will make available health care which is presently unavailable because of inappropriate regulations, having to do with who can be paid for what health

services are needed and provided.

2. Reimbursement should be for services provided by nurse practitioners and physician's assistants when there are three endorsements of the health care provided, one each from the patient, the health facility where provided, unless provided at home, in which case it could be certified to by a third person, and the nurse and/or assistant performing the work.

In addition, where patients do not speak, read or write American English, a declaration by the nurse and/or other assistant that the patient understands what has been done and the nurse and/or assistant understands the complaints

etc. of the patient.

3. Clinics in areas having 3% or more of a non-English speaking population, should provide bilingual/bicultural formats for effective communication and service across the board. In regular areas, physicians should be given credit toward their rural malpractice insurance for each medicare patient they treat. They should establish guidelines for nurses and/or assistants for health service delivery, particularly making "informed consent" a mandatory part of each service before it is performed.

4. The best certification probably should involve an awareness by the patient of the cost of the service to be performed related to the need for the service and an index of the indirect cost to the taxpayer of each service so that the illusion that the care is free will be off-set by the reality of tax funding.

In addition, if a review board finds health care services delivered, to have been unnecessary, excessive, and/or not indicated, reimbursement should be denied, both on a case by case basis, as well as an overall percentage of claims coming from a particular facility, thereby creating a climate for reasonable self-regulation. This is especially vital where patients do not speak, read or write American English since they are less likely to be able to complain on their own of deficiencies in the services rendered or in the results obtained.

To the extent possible some written and oral testing of physicians, nurses and assistants should be used to establish other language competence as a vital part of the reimbursement requirements in areas having 3% or more of non-English speaking population and especially if the patient is non-English speaking, otherwise this expansion of Medicare will be subject to abuses of the kind all too often seen already.

Respectfully submitted,

RICARDO A. CALLEJO, Counsel.

STATEMENT OF HON. MIKE GRAVEL, A U.S. SENATOR FROM ALASKA

I want to commend the initiatives of Senator Clark and Senator Leahy in introducing legislation to extend Medicare reimbursement to rural health clinics. The staff have done an exemplary job of drawing upon the experience of special interest groups and persons in the health field in developing this long-overdue legislation.

In Alaska the extension of Medicare reimbursement to rural health clinics will be significant. In an effort to address the difficulties imposed by distance, geography and weather, Alaskans have relied extensively on rural health clinics and physician extenders to provide consistent quality health care.

The passage of the Indian Health Care Improvement Act last year opened new vistas to the Indian and Alaska Native populations by allowing the Indian Health Service to be reimbursed for services provided to Medicare and Medicaid eligibles. Admittedly, the Medicare population among the Alaska Natives is not large. But it will increase, and the opportunity to receive reimbursement will enhance the financial viability of the rural health clinics in Alaska. In addition, the role of 3rd party reimbursement will improve the ability of Native Alaskans to manage the clinics independent of Federal control as provided in the Indian Self-Determination Act.

There are, however, several minor recommendations I would like to present to the Committee for its consideration. Although they would not substantively alter the bill, I think they would clarify terms and improve the future ap-

plicability of the legislation.

The term "rural health clinic" includes the qualification that "only a facility which is not located in an urbanized area (as defined by the Bureau of the Census) where the supply of medical services is not sufficient to meet the census) where the supply of medical services is not sumicient to meet the needs of individuals residing therein (including such rural areas as are designated by the Secretary as areas having medically underserved populations under section 1302 (7) of the Public Health Service Act, and clinics that receive a majority of their patients from rural medically underserved areas)" will qualify for reimbursement. While this language is broad and would include most of the Indian Health Service or tribal clinics, some would not be clearly eligible. Confusion over eligibility could cause unnecessary problems both for governmental agencies and intermediaries. To avoid this problem I recommend that all ambulatory facilities, either owned or leased by the Indian Health Service, i.e. health clinics, health stations, mobile clinics, school health centers, or similar Indian-and Alaska Native programs be specifically included as eligible. This would not abrogate satisfaction of the other rural health clinic definitional requirements.

One of the definitional requirements for reimbursement as a rural health clinic providing services to Medicare recipients is arrangements for utilization review. The term "utilization review" has traditionally defined the monitoring of hospital in-patient services. I question the applicability of this term to

ambulatory programs.

In an ambulatory rural health clinic quality control involves medical audit, not utilization review as it has come to be known. It is desirable to monitor the medication prescriptions, the laboratory tests, and in a multidisciplinary ambulatory facility, the activities of allied personnel, i.e. social workers, nutritionists, lab technicians, and physician extenders. Therefore, I think it would clarify the intent of the review if a more applicable term were used to indicate a medical audit or peer review.

The term "physician extender" as defined in the bill is a practitioner certified by the National Commission on Certification of Physician's Assistants or the American Nursing Association. I understand that the issue of adequate

criteria for certification of physician extenders is still evolving.

Although the above organizations provide sound guidelines for certification, I would suggest that it would be preferable to allow the Secretary greater discretion. Undoubtedly, he would refer to the criteria established by the two designated organizations, but he might also wish to include individuals certified as qualified physician extenders by the Civil Service Commission or accept State certification when it documents equivalent competency with national standards. By granting the Secretary discretion in certification the possibility of a more restrictive standard being adopted by the organizations would not pose any problem to the stability of the program.

STATEMENT OF HON. HOWARD W. CANNON, A U.S. SENATOR FROM NEVADA

Mr. Chairman, thank you for this opportunity to present my views on S. 708, which would amend Title XVIII of the Social Security Act to provide payment

for rural health clinic services.

As a co-sponsor of S. 708, it is a pleasure to provide some of my perspectives on what this legislation will mean to the patients of rural Nevada who are eligible to receive Medicare. I would also like to express my gratitude to Nevada health officials for their cooperation and assistance in the preparation of this analysis of the needs of my state's rural residents. I would like to particularly thank Dr. William M. Edwards, Chief of the Bureau of Community Health Services, Nevada State Division of Health and Dr. Wilford W. Beck, Director of Clinical Services, Rural Clinics, Nevada State Department of Human Resources.

The basis for this legislation is the state of the present Medicare program which disallows reimbursement for care provided by primary health clinics which happen to be located in less populous areas and do not have a full-time doctor on the premises. The reason for this situation is that many rural communities simply cannot afford to support a full-time physician, but they can support nurse practitioners and physician's assistants. The Social Security Act does not recognize this economic reality of our rural areas and penalizes

rural citizens by excluding them from Medicare coverage.

This result has been an unconscionable discrimination between urban dwellers and rural dwellers in the delivery of Medicare benefits. This situation

must be rectified and S. 708 will accomplish that goal.

The vast stretches of rural land in the beautiful state of Nevada encompass 96,000 square miles in which 112,000 Nevadans live. While those fifteen rural counties support approximately 19% of the total state population, rural residents only have 5.6% of the licensed physicians of the state.

Some individuals must drive up to 240 miles to reach the nearest, organized out-patient departments offering medical care. Consequently, most rural Nevadans do not seek physician level primary health care services; they wait

until an illness occurs before going to a doctor.

According to recent statistics, Nevada's population of senior citizens is increasing at the most rapid rate in the United States. However, the number of primary care physicians is barely holding even in Nevada's 15 rural counties. We must make better use of our physician extenders if we intend to meet the health care needs of the elderly. Removing the Medicare reimbursement restriction would certainly aid in better utilization of health care providers in a more efficient health program.

For the past three years, the Orvis School of Nursing at the University of Nevada, Reno has conducted a program to prepare registered nurses as Rural Nurse Practitioners. Unfortunately, very few of these nurses are currently involved in an organized primary health care program. The existing federal regulations requiring the presence of an on-site physician for reimbursement for services is a definite hindrance to organizing primary health care programs in Nevada. This legislation would provide the incentive to establish rural health clinics, making health care in Nevada more cost-efficient, sensible, and accessible. Moreover, it is nonsense to be producing qualified rural nurses for Nevada and then having no place for them to go to serve the people of Nevada.

Because of the rigidity of the present Medicare system and despite assurance of quality care from a licensed, certified registered nurse practitioner, last fall a clinic in Wells, Nevada had to disassociate itself from its parent institution, Elko General Hospital, 50 miles to the east. The clinic has since degenerated. Such results are patently unreasonable and undermine what should be a na-

tional commitment to keeping our people healthy and well.

Dr. Edwards, head of Nevada's Community Health Services, agrees with the idea that nurse practitioners should work in collaboration with licensed physicians, but disputes the notion that a physician need be watching over at all times. We can assure the people of Nevada that nurse practitioners can provide certain high quality health care services without direct physician supervision. The safeguards built into S. 708 will ensure that rural health services are maintained at a high quality.

I would also like to bring to the attention of the subcommittee another aspect of rural health care that is seemingly ignored in this legislation. That

is the matter of mental health services.

Although Part A hospital coverage under Medicare will allow care in a psychiatric hospital and Part B medical insurance grants limited coverage for outpatient treatment of mental illness, it is not clear under this rural health bill as to whether rural mental health clinics are also covered. If they are not, they should be.

Rural mental health clinics, such as the seven located in Nevada, experience much the same problem that physical health care providers have in terms of low-income families. Many families in rural areas lack the financial resources to obtain adequate health and mental health care. This problem is most acute

for the elderly on fixed incomes.

Until recently, the National Institute of Mental Health (NIMH) had given rural Nevada poverty area designation. As a consequence, the mental health program as well as other health care efforts, were able to obtain a more favorable match of federal funds and thus provide a greater amount of service. Changes in the NIMH formula for poverty areas has resulted in the loss of the poverty areas has resulted in the loss of the poverty designation for rural Nevada, although its people are no better off financially.

Legislation enabling rural citizens to use Medicare to benefit their total health picture is very appropriate. Oftentimes, one's physical health is de-

pendent on one's mental health as well.

While the proposed amendment to the Social Security Act, S. 708, focuses more on physical health care, I strongly endorse inclusion of a mental health

service provision.

Professional staff employed by rural mental health clinics in Nevada include Psychologists, Psychiatrists, Psychiatric Social Workers, Psychiatric Nurses, and Mental Health Technicians. A psychiatrist travels to each of the centers on a regular basis to provide services as required. The State of Nevada minimum qualifications for eligibility for the professional staff positions are as follows:

PSYCHIATRIST

Board certification or written confirmation that applicant possesses the necessary qualifications to be admitted to the certification examination of the American Board of Psychiatry & Neurology.

PSYCHIATRIC NURSE

Graduation from an approved school of nursing and one year of professional experience. Must be registered as a professional nurse in the State of Nevada.

PSYCHOLOGIST

A masters or doctoral degree in psychology from an accredited college or university, or satisfactory completion of the course requirements for the doctoral degree, plus experience in a psychological service capacity.

PSYCHIATRIC SOCIAL WORKER

A masters degree from an approved school of social work and two years of casework experience, or a bachelors degree and four years of casework experience.

CLINIC DIRECTOR

A masters degree and two years of clinical and community mental health

practice.

Any or all of these professionals, with or without additional requisites, are equivalents in terms of mental health care to the physician extenders in physical health care. The medical care that these mental health specialists could perform include inpatient care for emotional problems, partial/transitional care, and emergency mental health care.

The matter of coverage for rural mental health clinics deserves the careful attention of this committee. Provision under Medicare for meeting the mental health needs of persons living in the Hinterlands should be of the same avail-

ability as that which is already offered in the Metropolis.

In closing, I would like to compliment the committee for its efforts to correct shortcomings in the Medicare programs as affect rural health care. Passage of S. 708 is of vital concern to the rural citizens of Nevada and the millions of Americans who are interested in better health care delivery.

STATEMENT OF HON. WENDELL R. ANDERSON, A U.S. SENATOR FROM MINNESOTA

Mr. Chairman, I am very pleased to have the opportunity to submit testimony to the Subcommittee concerning Medicare reimbursement for rural health clinic services. As a cosponsor of S. 708, I hope to work with you and the members of the Subcommittee in developing and refining legislation to meet the

health needs of medically underserved rural populations.

Since over one third of Minnesota's population, or close to 1,300,000 people, is concentrated in rural areas, providing rural health care services is critically important in our State. Studies indicate that there are disproportionately high numbers of elderly people residing in rural locations who can benefit greatly from services provided by physician assistants and nurse practitioners in rural health care clinics. Under the present Medicare law, coverage for health services provided by physician assistants and nurse practitioners is prohibited unless a physician is present. In Minnesota where there are 297 rural towns with no doctor at all, and 62 such communities with only one physician, this prohibition can seriously limit sources of basic health care for rural Minnesotans.

In addition to the important medical services provided by rural health clinics, there is a continuing need for screening, preventive and referral services in these areas. One way of meeting these needs is through mobile health units such as the one in Polk County, Minnesota, which averages about 4,000 rural patient visits per year. Some of the services that can be provided by these units are blood pressure checks, health and nutritional counseling, glau-

coma screening, hemoglobin screening and diabetic testing.

Such services can be made available to people in remote rural areas who may have limited access even to rural clinics we've been discussing today. Through such programs, basic health education and screening so essential to maintaining good health can be provided to rural Americans who might not otherwise have use of them. I would be pleased to work with you and the members of the Subcommittee to explore ways of providing coverage for these and other preventive programs, perhaps by establishing a mechanism through which they can become affiliated with rural health clinics.

In conclusion, I would like to commend you and the Subcommittee members for your leadership in increasing the availability of health services to rural Americans, and will look forward to working with you in this effort.

STATEMENT OF HON. GARY HART, A U.S. SENATOR FROM COLORADO

Mr. Chairman, having cosponsored S.708, I would again like to indicate my earnest support for this measure, which will increase the access to primary health care services for rural medicare beneficiaries. This is a very necessary piece of legislation, and I hope that the Finance Committee members will also act as immediately as their busy schedule allows.

S.708 addresses a sizeable problem. Over 35 million Americans live in areas that are medically "underserved," that is, areas in which health status and physician supply are low. More than half of those areas are rural. Health care needs in rural areas vary significantly from urban centers. For some examples of this, let's look at the following characteristics of rural or remote areas.

When compared with their urban counterparts, a larger proportion of rural citizens have acute or chronic illnesses. This is largely due to the high concentration of poor and elderly people in rural areas. These are individuals who typically have extensive health care needs.

Rural areas suffer from serious geographic maldistribution of health personnel and facilities. Certainly, quality health care requires the availability of a wide variety of health care personnel and the resources to support them.

Additionally, because almost half of this country's poor live in rural communities, many rural residents are not able to afford the services they need. It is this problem of inability to pay for health care services and the problem of maldistribution of personnel that are the focus of our efforts here today.

The lack of physicians in rural areas can be attributed to a number of factors, including professional isolation, overwork, lack of continuing education, and inadequate support systems. Additionally, rural practices often make poor use of a physician's time. These problems have combined to make

the country doctor a thing of the past.

Coincident with the disappearance of the country doctor, however, has been the development of a new form of health care delivery, the "primary health care clinics are reimbursed by Medicare for their own services, physician excare provider groups that meet the basic needs of a given community. Primary health care programs employ many non-traditional approaches, but they are essentially organized substitutes for the country doctor. They provide individuals with diagnosis and treatment of routine health problems, and arrange for specialist care where necessary.

Because of the shortage of physicians in rural areas, these clinics are often staffed by a new kind of health professional known as a physician extender. Physician extenders include physicians' assistants, nurse clinicians, nurse midwives, nurse practitioners, family health associates and others of similar title who have been specifically trained in diagnosis and treatment for primary and

emergency medical care.

While rural citizens have come to rely on these clinics, many of the services provided by the centers are not eligible for reimbursement under Medicare. Part B of Title XVIII of the Social Security Λ ct, which essentially addresses the payment of doctors' bills and coverage of a variety of related services, is biased against the physical extender. While physicians practicing in primary care clinics are reimbursed by Medicare for their own services, physicians extenders are not. Services provided by extenders are reimbursed by Medicare only when a physician gives direct suprevision of these services.

This policy effectively excludes primary care clinics from Medicare reimbursement. And, as a result, Medicare beneficiaries in rural areas are denied the benefit of the clinics. The bill being discussed here today will help correct this debilitating problem by permitting Medicare reimbursement of qualified

physician extenders.

One final point. Over the years, the federal support for medical manpower development has been heavily oriented toward improving geographic and specialty distribution. Unfortunately, these efforts have achieved relatively little success. Doctors who go to rural areas rarely remain as an integral part

of the community. The physician extender offers one of the most economical and possibly one of the most effective techniques for providing health care in remote areas.

The time has come for the development of the extender role and to include primary health care clinics in the Medicare system. Such steps will greatly increase the financial access of the elderly to much needed health care services.

STATEMENT OF HON. DANIEL K. INOUYE, A U.S. SENATOR FROM HAWAII

Mr. Chairman, members of the Rural Development Subcommittee, I greatly appreciate the opportunity to present testimony on this proposal to provide

Medicare reimbursement for rural clinic services.

I believe that there is an urgent need for legislation of this kind. Statistics show that there is a large discrepancy between Medicare expenditures for rural and urban areas. Medicare reimbursements are lowest for nonmetropolitan counties with reimbursements per person averaging \$33.33 for metropolitan areas and only \$23.36 for nonmetropolitan counties.

Though there are various reasons for this difference, undoubtedly a major

one is simply lack of health care services in many of our rural regions.

This legislation would help to improve that situation by providing for payment under Medicare for services of health care providers other than physicians. Unless some change is made, the current inequity between Medicare expenditures for urban and rural citizens can only increase.

We are all deeply troubled by the continuing escalation in health care costs. Yet many rural and other citizens find that health care services are virtually

unavailable to them at any price.

I commend the chairman and the subcommittee for your recognition of the need for action on this issue. I have been concerned for some time about the restriction on reimbursements in the Social Security law which inhibits the full use of well qualified health care personnel and the development and expansion of health care services that are so badly needed.

I believe, however, that this restriction should be removed not only for rural clinics, but for other kinds of health services and in urban as well as

rural areas. However, S. 708 is a big step forward.

I would also object to the provision which makes reimbursement for nurses practitioner services contingent on physician "supervision." I think this is an unnecessary restriction that would curtail the benefit of the legislation. I believe that nursing services should be reimbursable and that physician supervision should not be required for payment. In fact, I have introduced legislation for that purpose. S. 104 would provide for the inclusion of the services of registered nurses under Medicare and Medicaid and would eliminate the requirement that such services be under the supervision of a physician.

The nursing profession has been rapidly broadening its traditional role. There are many clinics run by nurses both in rural and inner city areas of the country. Experience has shown that up to 80 and even 90 percent of the patients can be effectively managed by nurse practitioners. Many states already have amended their nurse practice acts to accommodate the nurse practitioner role. And, as is recognized in S. 708, the American Nurses' Association has established a program to certify nurse practitioners. The response to that certification program has been impressive. It was begun only last year, and more than 1.000 nurses already have entered the certification process.

Fuller utilization of these practitioners could greatly expand the availability of primary health care. It is ironic that our present system and reimbursement methods obstruct rather than foster the expansion of health care

services.

I believe that making this change also would contribute to the containment of health care costs. In many cases services now performed by a nurse practitioner, are reimbursable once they are recommended by and/or provided under the supervision of a physician. It seems logical that there would be a reduction in present costs, because of the elimination of the physicians' fees which, in most cases, are paid only for supporting the claims for payment. A

¹ Source: SSA, ORS, Health Insurance Statistics, Dec. 5, 1973, page 11.

recent study conducted at the Veterans Administration outpatient clinic in Los Angeles, showed that using nurse practitioners in adult ambulatory care facilities could increase the quality and volume of care at a cost considerably lower than for care provided by physicians. The study also showed a high degree of acceptance of the nurse practitioner by the patients and by the physicians who were involved in the project.

I strongly support changes in Medicare reimbursement policies which this legislation advocates. However, insofar as it relates to nurse practitioners, I would recommend that it be amended to identify nurse practitioners separately from the "physician extender" and to remove the requirement for physician

supervision for the services of nurse practitioners.

The nurse would, of course, work in collaboration with physicians, consulting and referring patients as appropriate. This is what actually happens now.

To make this change would only be recognizing what exists.

Again, I thank you for the opportunity to testify before the committee. I stand ready to work with you in any way that I can to bring about changes in Medicare reimbursement policies which will contribute to better health care for all the people in the country.

STATEMENT OF HON. THOMAS J. McIntyre, a U.S. Senator from New Hampshire

Mr. Chairman, thank you for the opportunity to testify before you today

on this most important issue.

Let me first say that I am proud to be associated with S.708 as a cosponsor, and I applaud these efforts by my distinguished colleagues Senator Clark and Senator Leahy to improve health service to rural areas. I have always been committed to providing quality health care for every individual in every region of our country. Unfortunately, under the present reimbursement regulations, many rural Americans are being discriminated against by the very programs designed to bring them quality care.

There are more than 15 million Americans who live in rural areas which are designated as medically underserved. This is compounded by the fact that the country doctor is on the wane as the great majority of medical students

are being lured to the more lucrative surrounding of urban America.

In New Hampshire, as in many other areas of the country, the rural health clinic is an invaluable source in dealing with the shortage of physicians. These clinics, staffed primarily with physician extenders, provide health services to many areas which are unable to support a full time physician. Without a proper method of reimbursement for extender services, the rural health clinic could well be placed in jeopardy at a time when the residents of these communities are becoming more and more dependent on their services.

One of the greatest injustices of the present reimbursement procedure is the additional hardship it places on our rural elderly. The elderly comprise a large proportion of the rural population and many of these individuals have no reimbursable primary health care services within easy reach of their homes. These people find themselves paying for Medicare Part B benefits only to turn around and be billed for the services performed by a physicians extender at the health clinic. This places an additional burden on those individuals who

are most in need of these services and least able to afford them.

Mr. Chairman, if we are seriously attempting to build a health care system to provide quality care for every person, maximum use must be taken of the skills and training of the physician extender and the services performed by the rural health clinic. With the escalating cost of health care in the past few years, alternative measures must be examined and utilized. It is unnecessary to require the attendance of a physician for minor medical procedures when these services can be competently performed by trained physician extenders. I also believe that the emphasis which the extender places on preventive care can provide an effective means by which we can ultimately control costs.

I have received a number of letters from my constituents in New Hampshire and from concerned individuals throughout the country urging my support

 $^{^2\,\}mathrm{The}$ Nurse Practitioner in an Adult Outpatient Clinic, DHEW publication (HRA) 76–29. January 1976.

for this legislation. These individuals have reiterated the potential effect this legislation would have in providing quality health care for so many rural Americans.

I am hopeful that Congress will act quickly and responsibly to end the present discriminatory reimbursement policy which affects thousands of communities throughout the country.

STATEMENT OF HON. JAMES T. BROYHILL, REPRESENTATIVE IN CONGRESS FROM THE 10th District of North Carolina

Mr. Chairman, I want to thank you and the members of the Senate Rural Development Subcommittee for the opportunity to speak in behalf of legislation to ensure that physician extenders can be reimbursed under Medicare for their services. As you may be aware, I have worked for the past several years in the House to make certain the implementation of such legislation, and I am glad that my colleagues in the Senate are now examining this issue.

Our government has been committed to training physician extenders for the past 10 years. Since that time, we have spent over \$70 million in the training of physician assistants and nurse practitioners. And, President Carter has requested \$9 million to carry on the work already started in these programs. However, when our elderly or disabled citizens seek the services of those physician extenders, they cannot receive reimbursement from the government under Medicare unless the physician was actually present at the clinic or facility where the services were performed.

In many cases, citizens are really paying twice for these services. Once, when they make their monthly payment for the optional Part B Medicare coverage, and again when they must reimburse the provider for services performed by trained professionals who have been recognized by the local community, the medical community, and the State and Federal governments. This does not even include their tax dollars which have gone toward the training

of the extenders.

North Carolina has been vitally involved in developing programs to train and utilize physician extenders. Through the Office of Rural Health Services, the state aided local communities in establishing primary care clinics, to be staffed by physician assistants and nurse practitioners. However, under state law the financial commitment to these clinics was for only three years, and funding has begun to run out in many clinics. The life of these, as well as dozens of other privately- and federally-funded extender clinics, such as those established by the Appalachian Regional Commission, may very well hang in the balance of this legislation.

The Congress has become increasingly aware of the need to deliver adequate health care to all segments of our population, but we are faced with the critical problem of the geographic maldistribution of physicians. This maldistribution has been especially notable in the rural and inner city areas. In the state of North Carolina during 1974, it has been estimated, 67 out of 100 counties possessed less than one primary care physician under age 60 for

each 4,000 in population.

As you may be aware, I have introduced legislation in the House of Representatives which would provide that the services of physician extenders be reimbursable under Medicare. I am proud to say that, as of this date, 45 other

members have joined with me in cosponsoring this legislation.

My approach calls for reimbursement under existing mechanisms, rather than creating a new system of payment in Medicare reimbursement. And, it ensures that all legally-recognized extenders will be covered, whether they work directly for a physician or for a clinic, in an urban or rural setting. To be reimbursable, a physician extender must be accredited by a federally-recognized accrediting body, and also be recognized by the state in which he or she practices. This will guarantee a quality control in that we can ensure extenders are qualified to practice and are working within the guidelines set by the respective states.

My bill calls for a simple amendment to Medicare law, creating no new level of bureaucracy and no confusion in administration. The federal government will not be injected into the day-to-day management and operation of

rural clinics.

The chronic problems of access and cost of medical services for our elderly and disabled can best be solved through the increased use of extender-staffed clinics. Study after study has shown that—not only does health service improve with the use of 'hese clinics, but total medical costs, including Medicare costs, actually decrease. I am sure my colleagues are aware of the studies carried out by Dr. John W. Runyan, Jr., reported in the Journal of the American Medical Association (JAMA January 20, 1975) and by Karen Gordon of Yale University School of Public Health and Gertrude Isaacs of the Frontier Nursing Service in Heyden, Kentucky, which support this conclusion.

Nursing Service in Heyden, Kentucky, which support this conclusion.

With the use of physician extenders, doctors are freed to perform more complex and time-consuming services. Extenders can perform to their fullest capacity. The patient, the physician, and the extender all benefit. These benefits, I believe, are being proven at this very time in clinics throughout the country.

Part B of Medicare was enacted before the use of physician extenders became widespread. It was not possible to foresee extender reimbursement as a necessity until physician extender services became firmly rooted in our health care delivery system. I feel it is important that we seize this opportunity to establish our government's policy with regard to health care in general and physician extender services in specific. We will move one giant step closer toward our goal of adequate health care for all Americans with the enactment of legislation to reimburse physician extenders under Medicare.

STATEMENT OF HON. RAY BLANTON, GOVERNOR, STATE OF TENNESSEE

Primary care centers in over 30 counties in rural Tennessee utilize physician extenders with physician back-up services in order to provide primary medical care in areas where severe physician shortages exist. The legislation before your Committee would recognize the medical skills of the physician extenders and allow for much needed reimbursement for their services whether or not

the physician is on the premises.

Although studies have indicated the cost-effectiveness of extender-staffed primary care clinics in rural areas unable to obtain and/or support physicians, these clinics are penalized by inequitable reimbursement practices that make self-sustaining clinic operations difficult. In Tennessee, we have funded through the Appalachian Regional Commission 19 of these physician extender-staffed clinics. The first of these clinics to reach the five-year ARC funding limitation is in Clairfield. We now know that this clinic will not be able to continue services when federal funding ceases unless reimbursement policies and legislation are changed. Medicare reimbursement to physician extenders will not solve all financial problems of these clinics. The citizens served are often on fixed incomes or underemployed. However, reimbursement on a cost-of-services basis would significantly contribute to the support of extenders. It would also allow the elderly to take full advantage of the services currently offered in or near their home communities.

Difficulties of access to medical care in Appalachian Tennessee are compounded by multiple problems of isolation, poverty and inadequate transportation, as well as by the lack of available physicians and dentists. Forty-three of the Tennessee Appalachian counties are or recently have been on the HEW medically underserved area list. While Tennessee is addressing as a high state priority the training and retention of family practice physicians, the immediate need for medical care in much of rural Tennessee is being met by physician extenders. These extenders practice using protocols jointly developed with their supervising physicians and have physician guidance available to them at all times. The increasingly important role of these extenders in educating rural residents in preventive aspects of health care is an added benefit provided by the clinic's staff. Senior citizens on fixed incomes need the full range of preventive, maintenance and primary medical care provided by the physician extenders; yet they are reluctant to utilize these services when medicare, usually their primary means of payment, cannot be utilized as payment for physician extenders service.

I personally instructed my ARC staff to work in coordination with other state ARC staff members to coordinate the development of a resolution concerning medicare reimbursement of physician extenders. I cosponsored this resolution which was passed by the ARC on June 8, 1976. Our resolution is based

on experience obtained in more than 87 primary care centers staffed by physician extenders and supported by ARC (19 of these in Tennessee). We have found primary care services provided by these extenders to be of commendable quality. We have also found that services provided in this manner help to prevent cost escalation for health care services provided to medicare beneficiaries.

We support reimbursement for physician extender services only when the extender is acting under written standing orders agreed upon by a fully licensed physician and when such physician assumes full legal and ethical responsibility as to the propriety and quality of the services rendered. We further maintain that reimbursement should be provided on the basis of the services rendered whether rendered by physicians or physician extenders and that the reimbursement should be made on a cost of services basis and paid to the clinic or sponsoring organization.

The primary reason for original funding of these primary care clinics by the ARC was to extend the availability of physician supervised medical services to rural citizens who otherwise would not be able to obtain adequate health care. Unless reimbursement under medicare can allow coverage for services provided by physician extenders, this goal cannot be realized. We appreciate your interest and concern regarding the problems of financing rural health

care.

APPALACHIAN REGIONAL COMMISSION RESOLUTION NUMBER 407

A Resolution Concerning Medicare Reimbursement of Physician Extenders. Whereas, the 1972 Amendments to the Social Security Act, P.L. 92–603 directed the Secretary of the Department of Health, Education and Welfare to examine the quality, cost and range of health care that can be appropriately delivered by non-physician providers, and to determine the constraints that should be imposed in order to permit Medicare reimbursement for services provided by such persons; and

Whereas, in Senate Report 94–278 accompanying the 1972 Amendments to the Appalachian Regional Development Act, the Public Works Committee of the Senate noted, as a serious problem, that present Medicare regulations do not recognize or permit reimbursement for primary health care services provided by a nurse practitioner or other physician extender, unless a physician is physically present; and urged consideration of this problem by the Senate Finance Committee and the appropriate Committee of the House; and

Whereas, the Appalachian Regional Commission, together with the Tennessee State Health Department, the North Carolina Office of Rural Health Services, the Kentucky Health Resources Development Institute, the Frontier Nursing Service, the West Virginia Regional Medical Programs, the Tennessee Valley Authority, the United Mine Workers Health and Retirement Funds, the Southern Labor Union, and the Vanderbilt Center for Health Services, among others, have found by trial and careful testing, that physician extenders do provide appropriate primary health care, especially to persons in medically underserved areas, who otherwise would have limited ability to exercise their entitlement to Medicare services; and

Whereas, physician extenders are physician assistants, nurse practitioners, nurse clinicians, or other trained practitioners, who have successfully completed a program of study approved by the National Board of Medical Examiners, or who are licensed or otherwise recognized by a State as qualified to provide primary health care services in the State in which such services are

rendered; and

Whereas, the Commission and other sponsoring agencies above mentioned have also found the services provided by these physician extenders, who function in organized systems of care (whether or not performing in the office of, or at a place at which a physician is physically present), to be of commendable quality; and

Whereas, the above-mentioned beneficiaries have also found that services provided in this manner help to prevent escalation of health care costs for

Medicare beneficiaries; and

Whereas, Section 102(a)(3) of the Appalachian Regional Development Act authorizes the Commission to review Federal, State and local public and private programs, and where appropriate, recommend modifications to increase their effectiveness in the Region: Now, therefore, be it

Resolved, That the Appalachian Regional Commission recommends that Title XVIII of the Social Security Act, Part B Supplemental Medical Insurance (42 USC 1305), and all such other medical entitlement programs be amended to permit:

(1) Reimbursement for primary health care services provided by physician

extenders, as defined above, when the following safeguards are met:

(a) The physician extender is functioning in an organized system of care;(b) The physician extender is acting under written standing orders agreed upon by a duly licensed physician (whether or not such services are performed in the office of, or at a place at which such physician is physically present at the time of the specific service); and

(c) The physician providing the written orders assumes full legal and

ethical responsibility as to the necessity; propriety and quality thereof;
(2) Such reimbursement be provided at a rate commensurate with the service provided rather than according to the provider of care; and

(3) Such reimbursement be made to the clinic or sponsoring organization. Approved: June 22, 1976.

MILTON J. SHAPP,

Governor of Pennsulvania. State Cochairman.

DONALD W. WHITEHEAD. Federal Cochairman,

MONTEFIORE HOSPITAL AND MEDICAL CENTER, Bronx, New York, N.Y., March 29, 1977.

Senator DICK CLARK, U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: I write to you in SUPPORT of S 708, providing the phrase "physician supervision" is replaced with the phrase "physician consultation which is reimbursable".

I hope you will give careful attention to the testimony of Anne Zimmerman,

President, ANA, on this matter.

Thank you.

Sincerely yours,

SUSAN W. TALBOTT, R.N., M.A., Nurse Recruiter.

CORNELL UNIVERSITY. NEW YORK HOSPITAL SCHOOL OF NURSING, New York, N.Y., April 1, 1977.

Mr. DICK CLARK.

U.S. Senate, Washington, D.C.

Dear Mr. Clark: I would like to call your attention to Federal Legislation S708.

As an educator and certified nurse practitioner, I would like to see the wording "physician supervision" changed to the realistic, "physician consultation." Also, the title "Physician Extender" should be replaced by "Nurse Practitioner." Nurse Practitioner are independently licensed professionals who are responsible for their own acts—Bill #8708 should reflect this.

Thank you.

Sincerely,

BONNIE JONES FRIEDMAN, R.N., C, Assistant Professor of Nursing.

UNIVERSITY OF IOWA HOSPITALS AND CLINICS, DEPARTMENT OF FAMILY PRACTICE. Iowa City, Iowa, March 22, 1977.

Hon. DICK CLARK, Chairman, Senate Rural Development Subcommittee, Russell Bldg., Washington, D.C.

Dear Mr. Clark: Thank you for the opportunity to comment on this most important area of proposed legislation. Although I have only recently joined

the faculty of the University of Iowa, Department of Family Practice, as the Medical Coordinator of the Network of Family Practice Residency Program, recent experience has been involved with the other major area of the medically underserved, the inner city. There are many similarities, of course, in the problems of health care delivery in rural America and those of the

inner city.

I believe that a major obstacle to the implementation of the concepts of interdisciplinary health teams has been the problem with reimbursement for the services of nonphysician health professionals. The residency program which I previously directed at San Francisco General Hospital taught and practiced in an interdisciplinary fashion with the objective of motivating the residents to practice in a similar way on completion of their training. It is, I believe, highly significant that the only graduates to do so are those who chose to work in clinics supported primarily through public funds, both municipal and federal—in which other health professionals were salaried. The stated reasons that those physicians who chose to go into private practice failed to work with other health disciplines involved their concern about the economics of such practice modes due to the reimbursement restraints.

In consequence of my experience I feel strongly that the most effective stimulus to the development of a health care delivery system using an interdisciplinary approach will depend on physician cooperation and innovation. Such physician participation would be encouraged by a strategy which parallels the existing care structure: the reimbursement of the physician for patient care services performed by a non-physician health worker who is supervised by the employer-physician. Their supervision should be defined in a manner which allows for supervision by a physician not physically present

on a permanent basis.

I have limited my remarks to those areas of the proposed legislation in which I have had significant experience. I thank you for this opportunity.

Sincerely,

ROBERT J. MASSAD, M.D., Coordinator of the Family Practice Network of Affiliated Residency Programs.

THE UNIVERSITY OF NEBRASKA MEDICAL CENTER, Omaha, Nebr., March 24, 1977.

Hon. DICK CLARK, U.S. Senate,

Russell Office Bldg., Washington, D.C.

Dear Senator Clark: Thank you for allowing me to comment on S. 708

pertaining to Medicare reimbursement of Physician Extenders.

It has become more evident that rural health physicians have found a need to utilize Physician Extenders. This has increased his efficiency and quality of care in general. I feel that Physician's Assistants can help their physicians immensely in continuing this pattern. Medicare reimbursement for services performed by a Physician Extender would greatly add to that. In my opinion, 80% reimbursement to the physician who employs the P.A. would be equitable.

I would define a Physician Extender as an individual who has been certified by the National Commission on Certification of Physician's Assistants to the primary care physician. This certifying examination is open to Physician Extenders and is of highest quality. The Physician Extender must also be under the responsible supervision of a physician. To allow the use of a "collaborative" physician instead of a "supervising" physician could greatly jeopardize the concept of the Physician Extender. This, in itself, opens the door to an independent practitioner without supervision.

Most of my colleagues in Nebraska are in rural areas of less than 5,000 population. They wish to remain and continue in giving quality care to all people of all ages. This amendment would greatly aid in giving rural Ne-

braska the quality of care they justly deserve.

Thank you for allowing me to express my opinion on this issue, and also for your concern in this very important matter.

Sincerely,

KIRKSVILLE COLLEGE OF OSTEOPATHIC MEDICINE, Kirksville, Mo., March 28, 1977.

Hon. DICK CLARK. Senate Rural Development Subcommittee, 404 Russell Bldg., Washington, D.C.

DEAR SENATOR CLARK: Thank you for the opportunity to submit written

testimony for the Subcommittee Hearing on S. 708.

We strongly support S. 708 and the concept of providing Medicare reimbursement to support Rural Health Clinics and Communities that lack full time physicians extenders. There are literally hundreds of small communities in the State of Missouri that do not have primary care and treatment. In fact there are some entire counties in the state that are without primary health care of any kind.

There is little, if any prospect, that these small communities and counties can recruit and retain full time licensed physicians. At the same time, a substantial amount of primary health care can be provided by physician extenders working under the supervision of a licensed physician, and being

reimbursed by third party payors.

Actually, this College has conducted a de facto physician extender program for nearly thirty years. Senior student physicians, under the supervision of licensed physicians, staff nine Rural Extension Clinics in small towns, without resident physicians within a 50 mile radius of Kirksville. These Clinics provide primary health care which would not otherwise be available. Again, we strongly support S. 708 and deeply appreciate the opportunity

of giving testimony in favor of it.

Cordially,

J. S. Denslow, D.O.

UNIVERSITY OF WASHINGTON, Seattle, Wash., March 25, 1977.

Hon. DICK CLARK.

Chairperson, Rural Development Subcommittee of Senate Agriculture, Nutrition and Forestry Committee, Old Senate Office Bldg., Washington, D.C.

DEAR SIR: Please replace the word "supervisor" in S708 with the phrase "physician consultation". The nurse practitioner is a primary care provider who is prepared to give continuous, personalized care to the patient/client when he enters the health care system. Since the nurse practitioner is legally responsible for her own acts, consultation is more appropriate than supervision as many doctors are not physically present in rural areas where nurses are giving care. It is highly important for rural health care in this country that nurses be able to be reimbursed for their services.

Sincerely,

ROSEMARY PITTMAN, Associate Professor, Project Director.

THE UNIVERSITY OF SOUTH DAKOTA, SCHOOL OF MEDICINE, Vermillion, S. Dak., March 22, 1977.

Hon. RICHARD CLARK, Senate Rural Development Subcommittee, U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: Thank you and the total committee for giving consideration to a very important matter for people who live in rural areas. Title XVIII people are not discriminated against if they live where there are no doctors but where there is a physician extender (physician's assistant or nurse practitioner). They can get the only care they get from physician extenders but cannot be reimbursed by Medicare (Title XVIII) for it. As you know there is no such problem for a medicare patient if the extender he goes to for care practiced in the same building with a doctor. I read, with great pleasure, Senate bill 708, and would like to comment

as follows:

Legislation like S.B. 708 would provide payment for the senior citizens on Title XVIII in our communities whereas, now, they are not able to have these services paid for and are, therefore, discriminated against. It would rectify a gross injustice. Approximately 10-15% of our patients are on Title XVIII.

Reimbursement should be made for the services of physician's assistants and nurse practitioners. The reimbursement schedule should be standardized according to the physician's charges in the community since to charge less than they do would indicate inferior service. If we do the same work, we should get the same reimbursement. State laws have already described in some detail what services may and may not be rendered by a physician extender.

State laws have already, in great detail, spelled out what physician participation must be (in our state at least one day per week with each satellite clinic). It has also spelled out arrangements for referrals, management policies, etc. Therefore, it seems that agreement for participation and, therefore, reimbursement should be certification by the said state. I suspect that each state will do an excellent job of policing. However, the audit and review quality of care can be done by the agency (Social Security) as well as the P.S.R.O. group in that state.

Certification process for these providers of physician extender services should be that of the states. Most have already chosen in their laws for physician extenders to follow the route of the National Examination by the these providers of physician extender services national group. P.S.R.O, would reveal if there is any discrepancy in quality of care and could deny payment for less than the quality it demanded. We wholeheartedly agree with that principle.

We welcome P.S.R.O. (the only offices and clinics which would be covered by that law) to prove that what we are doing is of quality.

The only problem not addressed in the bill, Senator Clark, is that of those physician extenders who were certified by states before there were any national organizations or national examinations. Most of them would have been certified by the states prior to 1974. They could take the national exams but the respective national organizations will not allow them to do so because the states of the stat cause they did not attend a nationally recognized program which simply did not exist at that time. The answer to this might be amended into your bill by stating that these people be certified by a state to provide services are physician extenders. This could be placed in Section 1861 b, 3. This is the part which deals with definition of physician extenders.

Thank you and the committee for listening to the grass roots. The good you do for older people is appreciated—not only by them but by those of us

who will soon be in that same age category.

Sincerely,

ROBERT H. HAYES, M.D., Director, Physician Extender Program.

STATE OF WISCONSIN. DEPARTMENT OF HEALTH AND SOCIAL SERVICES, Madison, Wis., March 28, 1977.

Hon, DICK CLARK.

Chairman, Rural Development Subcommittee, U.S. Senate Agriculture Committee, 404 Russell Office Bldg., Washington D.C.

DEAR SENATOR CLARK: On behalf of the State of Wisconsin, Department of Health and Social Services, I wish to support the bill which you and Senator Leahy introduced and which is now before the Rural Development Subcommittee. S 708 would be well-received by Wisconsin's elderly, medicallyunderserved population. I regret that the bill does not provide Medicare and Medicaid coverage to all underserved populations-both urban and rural. There are already at least six sites in Wisconsin where this type of rural health clinic is in operation. Extenders, under varying degrees of physician supervision, are and could be providing a viable alternative to Wisconsin communities which would otherwise be forced to go without adequate primary health care services. More sites have been conceived, but their development is inhibited by lack of third-party reimbursement and by a growing reluctance on the part of cooperating physicians to alter or jeopardize their practices in

order to conform to anachronistic reimbursement policies.

S. 708 will remove the Medicare proscription of physician extender use in rural medically-underserved population. It recognizes, however, that simply needs created by spatial and specialty maldistribution of physicians and other providers. Neither can it be expected to meet all the health care needs of a rural medically-underserved population. It recognizes, however, that simply producing more physicians is no longer a satisfactory or cost-effective policy response to alleviating shortages of primary care services.

Any analysis of physician shortages or efficacious use of primary health practitioners (nurse practitioners, physicians' assistants, or other "physician extenders") must recognize that the shortages in question are shortages of health services—not necessarily of physicians. Physicians provide services, but others can provide, in many instances, the same services. S. 708 releases us from the physician fixation and enables local communities and providers to search for ways to provide services. One cannot ignore the number of physicians, for their increase may be warranted, but physicians are an input, not an end product. Neither the National Health Service Corps nor the Rural Health Initiative programs alone can realistically be expected to make low cost health care available to all citizens.

Given the current practice of medicine and existing reimbursement policies, Wisconsin estimates that it needs anywhere from 100 to over 1,000 primary care physicians. To train and retain one physician in the state can cost up to \$700.000. Even then, there is little guarantee that the needs of rural, underserved persons will be met. If, however, Wisconsin's primary care physicians could be interfaced with a coordinated network of rural health clinics, staffed by physician extenders, then quality health care can begin to

be made more accessible.

Physician extenders can be trained at one-fifth to one-tenth the cost of a physician. Studies show that the physician extender can increase physician productivity from 25 to 74 percent. Further, physician extenders can be more easily recruited and located in rural areas than physicians, and they tend to remain in primary care. But physician extenders will not be fully utilized as long as their services are not reimbursable and as long as restrictive prac-

tice acts preclude their full use.

S. 708 is a practical answer to a pressing need. It does not try to settle the myriad issues surrounding use of new health practitioners or the relationship between them and the primary care physician. It permits an underserved community to organize itself (or be organized), to develop a workable tie between primary health practitioner and physician, and to receive primary care services. S. 708 recognizes and sanctions a practice which is being increasingly and safely utilized in this country to make health care more accessible.

Since 1972, Wisconsin has been committed to a policy that adequate health care is a right to which every citizen is entitled. This commitment cannot and will not be met by restrictive reimbursement policies such as Medicare, Part B. S. 708 should be supported because it provides for cost containment without being inflexible to the uniqueness of local situations. S. 708 could even reduce costs by not requiring Medicare beneficiaries to pass through a physician—at increased cost—in order to obtain reimbursable services. There is also compelling evidence that the use of physician extenders can reduce costly hospitalization experience and that the social costs of geographic maldistribution of physicians would be greatly lessened.

Wisconsin is now investigating the feasibility of changing its own Medicaid reimbursement plan to conform with the proposed change in Medicare. Such changes have been recommended by some local Health Systems Agencies through their Health Systems Plans. It is imperative that rural and underserved people, including large numbers of elderly, are not denied health care

services which could be provided through innovative methods.

I look forward to the successful legislative journey of S. 708, and would provide whatever additional help the Committee may find useful.

Sincerely,

THE UNIVERSITY OF VERMONT,
DEPARTMENT OF MEDICINE,
Burlington, Vt., March 22, 1977.

Re Hearings, Senate Rural Development Subcommittee.

DAVID HARF,

Office of Senator Dick Clark,

404 Russell Bldg., Washington, D.C.

Dear Mr. Harf: The remuneration of nurse-practitioners and physician's assistants operating independently should be supported only in those situations where adequate professional standards are ensured. Licensure standards or certification by states following completion of an accredited course is one method of assuring good quality services. Continued measures of performance through some form of accountability (record audit or professional review) would also be necessary. The ability to assure financial support of physician's assistants or nurse-practitioners functioning in rural communities would assure their persistence.

The participating clinics or organizations should assure available physician supervision and should also set policy on a local basis for patient referral and management. Protocols should be developed for nurse-practitioner or physician assistant participation, and a physician should be identified as the responsible agent for ensuring accountability and audit of patient man-

agement

The ability of physician's assistants or nurse-practitioners to act independently without the presence of a physician, should release physicians from some of their obligations. The availability of these paraprofessionals should increase the number of preventative and screening services possible in rural areas. If there is better disease prevention, earlier detection, and improved overall patient care, the effectiveness of such a program should cover the costs incurred.

Sincerely,

JEROME W. YATES, M.D., Associate Professor of Medicine.

THE UNIVERSITY OF IOWA, COLLEGE OF MEDICINE, Iowa City, Iowa. January 4, 1977.

Hon. Dick Clark, U.S. Senate, 404 Russell Senate Office Bldg., Washington, D.C.

Dear Senator Clark: We are pleased that you plan to introduce legislation soon to amend the Medicare policy regarding reimbursement for services provided by physician extenders at "remote sites." We appreciate the opportunity to comment on the draft of your bill dated December 20, 1976. To respond by January 5 as you requested, we have limited our comments to three areas: the scope of the bill, areas of potential misinterpretation and procedural points set forth in the bill.

EXTENDING THE SCOPE OF THE BILL

The potential for improving accessibility to primary medical services by using physician extenders will not be fully realized if Medicare reimbursement for an extender's services are limited to their provision in or by a "rural health clinic." Three remote sites—other than a rural health clinic—where an extender might provide services without the personal presence of the supervising physician are a patient's home, a nursing home and a hospital outpatient department. Withholding Medicare reimbursement for the services of an extender at these sites (and others) would limit the gains in accessibility that could be achieved if the proposed modifications in policy would be extended to all remote sites where appropriate physician supervision is maintained. We would define "remote site" as any place where the responsible physician is not physically present at the time a service is rendered.

AREAS OF POSSIBLE MISINTERPRETATION

The Medicare Program currently reimburses a physician for his/her professional services, and incidentals to the provision thereof. It is our under-

standing you are proposing that Medicare also reimburse a physician for the professional services and incidentals provided by a physician extender he/she employs and supervises. We believe this language is preferable to "rural health clinic services" in that it is specific as to what services are covered and to whom reimbursement is made. It is our view that to maintain adequate supervision of an extender's work, and to maintain public accountability for professional services rendered, the extender must have an employee-employer relationship with the supervising physician (or the extender and the supervising physician must be under contract with the same third party). The bill as currently written could be misconstrued as enabling Medicare funds to be paid directly to a physician extender or his/her non-physician employer. We could not support a proposal which encouraged or permitted independent medical practice by a non-physician. Many states, including Iowa, do not permit a physician extender to be engaged in independent medical practice (a copy of Chapter 148 from the Code of Iowa is enclosed for your review).

The second area of possible misinterpretation concerns Section 1, (aa), (I)—phrases (i) and (ii) on page 2 of the draft we received. Contrary to phrase (i) which requires the "facility" to be located in a rural physician shortage area, we believe the proposed bill should be applicable in all geographic areas. There are three reasons we recommend removing the requirement stated in (i): first, it is extremely difficult to objectively determine "physician shortage areas"; second, bonafide shortage areas may not receive such designation because persons there do not request it; and third, urban areas could also benefit from extenders' services in remote sites. The experience in Iowa with the National Health Service Corps supports the first two points. Regarding phrase (ii), we believe the intent of this phrase is to define "remote site." However, an interpretation of phrase (ii) could be that services, provided in a clinic in a small rural community which is operated under the direction of physicians in a nearby community and staffed by a physician extender employed by them, could not be paid by Medicare. We do not believe it is your intention to exclude this type of arrangement.

PROCEDURAL CONSIDERATIONS

Section 1 (a), (i) indicates "payments shall be based on the audited costs incurred . . . or such other tests of reasonableness as the Secretary may find appropriate." We believe it is important to have a provision for audit if there is suspicion of fraud, but determining routine payments by audit seems infeasible; leaving this matter up to the Secretary seems too ambiguous. We recommend continued use of the "usual, customary and reasonable" policy presently employed by Medicare, with the additional requirement that physicians employing extenders must accept "assignment" (i.e. direct payment from the Medicare intermediary) for the claims submitted for services performed by the extender at a remote site. This is the approach being used in the Social Security Administration's Physician Extender Reimbursement Study. To impose a more burdensome approach to determining Medicare reimbursement would defeat the objective of expanding the use of physician extenders in remote sites.

We hope these comments and suggestions will be helpful to you in refining your bill to amend the Social Security Act. Please contact us if we can be of further assistance.

Sincerely.

Paul M. Seebohm, M.D.

Executive Associate Dean.

Bruce Brenholdt,

Office of Community Based Programs.

THE UNIVERSITY OF IOWA, COLLEGE OF MEDICINE, Iowa City, Iowa, March 25, 1977.

DICK CLARK, U.S. Senate, 404 Russell Senate Office Bldg., Washington, D.C.

DEAR SENATOR CLARK: The College of Medicine is pleased the senate Rural Development Subcommittee is conducting further hearings on the sub-

ject of Medicare reimbursement of "rural health clinic services." We are especially pleased you invited Dr. Jack Fickel, Medical Director of the College's Regional Primary Care Program, to present oral testimony on S. 708.

In regard to the invitation we received from you to submit a written testimony concerning S. 708, Dr. Seebohm and I have no comments beyond those cited in our letter to you dated January 4, 1977 (attached).

Thank you for contacting us in regard to this legislation.

Sincerely,

Bruce Brenholdt,
Office of Community Based Programs.

THE RURAL PRACTICE PROJECT, Chapel Hill, N.C., March 23, 1977.

Hon. Dick Clark, Chairman, Senate Rural Development Subcommittee, 404 Russell Bldg., Washington, D.C.

Dear Senator Clark: Thank you for your recent letter describing the hearing on March 29 dealing with Medicare reimbursement of rural health clinic services. In response to your invitation, I am happy to give you written

testimony for the hearing.

The use of intermediate level practitioners, such as physician assistants and nurse practitioners, is a key factor in supplying health care services on the rural countryside. Without amendments to the present statute, financial reimbursement for these valuable services is often impossible and the growth in the use of such important members of the health care team is slowed

and prevented.

As you know, for eighteen years I was Administrator of Fairmont Clinic, a multi-specialty physician group practice complex which furnished a variety of health care services to residents of several counties in West Virginia. We observed and lived with the increasing shortage of physicians in rural areas, and the decline of physicians-to-population ratio as a reality. Through sheer necessity, rather than by development of theory or concept, we slowly came to use intermediate level practitioners starting several years ago. We were then pioneers in placing physician assistants in rural satellite offices which had physicians only on a parttime basis. With careful supervision, high quality supportive services and good medical records, there was universal commendation for this service by outside, professional, objective observers.

In the course of the last few years, it has been my privilege to serve in a keynote or principal speaker capacity at a variety of major professional meetings where rural areas were represented. Universally, I have found that those who attended these sessions believed that the use of nurse practitioners and physician assistants was a compelling necessity for rural America. They were frustrated by the failure of third-party agencies and insurance carriers to reimburse for such services. Most of all, it was difficult for them to understand, whether as consumers and community leaders or as professionals and providers, how the federal government through Medicare reimbursement continued to deny payment to intermediate level practitioners who perform such valuable and progressive services in the health care delivery system.

Such issues were raised as early as the First Arizona Conference on Rural Health held in Tucson in 1972. These issues resurfaced at the National Conference on Rural Health Maintenance Organizations at Louisville, Kentucky in July, 1974. You will recall that your Subcommittee on Rural Development of the Committee on Agriculture printed the proceedings of that session. In 1975, at two other national meetings, one on HMOs and the Rural Medically Underserved in San Francisco, and the National Conference of Family Health Centers at Salt Lake City, the need of payment mechanisms for nurse practitioner-staffed clinics was conveyed. Last year as I spoke to the first Wisconsin Rural Health Conference held in Oshkosh and to the Iowa Conference on Rural Health Manpower in Des Moines, discussion at entire panels focused on the necessity for an intelligent system of reimbursement for these valuable intermediate level practitioners' care.

In my present position, I travel the nation from Delaware to Oregon, from Minnesota and Vermont and Montana to Georgia and Mississippi and Texas, visiting small rural communities in need of improving their health services.

The Robert Wood Johnson Foundation and its Rural Practice Project are attempting, on a modest scale, to provide models of primary care practice (with physician assistants and nurse practitioners) which may influence a larger proportion of future health care professionals to live and practice in rural America.

It is clear that the rural population which has greater health needs receives much fewer health services than urban people. It is equally clear from available statistics that those in the most isolated rural counties are subsidizing, in effect, under the Medicare Part B payment system, the much

superior services received by residents of metropolitan counties.

Since the nurse practitioner issue is almost a life-and-death one for many small rural communities, it is most appropriate that a Congressional Committee which holds such concerns at the center of its interests, move actively at this time to secure changes in the legislation which will allow reimbursement under Medicare for such services.

Your Committee is to be congratulated for its efforts over the years to

improve health care services for rural people. In doing so, it has acted with

a unique practicality to achieve humane and progressive goals.

Sincerely,

M. H. Ross, Associate Director.

COMPREHENSIVE CARE FOR CHILDREN AND YOUTH, UNIVERSITY OF VIRGINIA MEDICAL CENTER, Charlottesville, Va., March 23, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

Dear Mr. Harf: As a Nurse Practitioner providing care to patients in rural areas, I would like to voice my support for Bill S. 708, permitting Medicare-Medicaid reimbursement to rural health clinics for primary health services.

Emphasis on primary care is warranted because of its role in improving health, promoting rural development and fostering long-term reductions in the total cost of health care. Primary health care is typically the most deficient type of care in rural communities.

The following excerpt from the Report and Recommendations of the Southern Rural Health Conference, lends support to your proposed bill.

"Medicaid, Medicare, private health insurance, and national health insurance (if implemented) should cover primary health center services. Eligible providers should include all non-profit ambulatory health centers providing primary health services and staffed by primary health physicians and/or primary health practitioners employed on a reasonable salary basis. Reimbursements should be on a reasonable cost basis not fee-for-service, with a minimum productivity standard based upon maturity and location of centers. Primary health practitioners include nurse practitioners, physician assistants, MEDEX, nurse midwives, and other providers providing primary care in accordance with state laws."

Better primary and preventive health services have the potential to improve the overall health of our rural residents while decreasing costs for medical

care and decreasing serious hospitalizations.

Respectfully.

ANDREA L. SNYDER, R.N., P.N.C., Chief Nurse.

MEHARRY MEDICAL COLLEGE. SCHOOL OF MEDICINE. Nashville, Tenn., March 18, 1977.

Senator RICHARD CLARK, Chairman.

Senator Patrick Leahy.

Member, Senate Rural Development Subcommittee, c/o David Harf, Office of Senator Clark, 404 Russell Bldg., Washington, D.C.

Dear Senators: This is to endorse the main principle of your bill \$708 and to agree with most of your remarks of February 10, 1977 (Congressional Record V. 123, no. 25). Attached are reprints of work we are doing to help found and maintain rural health clinics with teams including physician extenders—such as the Rossville, Tennessee Poor People's Clinic.

However, the same principle should apply to all Federal reimbursement programs—Medicaid, Champus, V.A., Vocational Rehabilitation and the like.

Medicare is only for persons over age 65. All age groups are affected.

In addition, it would be uniting of rural and city people if the bill included urban doctor shortage community clinics. The inner city tends to have as bad doctor shortages as the rural areas.

A national health service is necessary to back, not just national health

insurance.

Reimbursement should be made to the clinics, not to the physician extender as a fee. Fees may be corrupting to health care providers. A "provider number" should receive reimbursements.

Cordially yours,

Leslie A. Falk, M.D., Professor and Chairman.

Enclosures (2): "The Potential Role of the Medical School in Rural Health Care Delivery"; "Family and Community Health Sciences at Meharry Medical College—in Historical Context." 1

STATEMENT OF STEPHEN NYE BARTON, M.D., DIRECTOR, CLEARINGHOUSE FOR RURAL HEALTH SERVICES RESEARCH, UNIVERSITY OF ALABAMA

I support Medicare reimbursement for rural nurse practitioners physician's assistants that are not supervised directly by physicians. The entire problem can be best understood by applying a systems analysis. Let us for a moment consider the patient as a throughput of a system. When the patient enters a clinic (or even prior to entering a clinic) for the treatment of an illness there are a number of systems of activities that can be activated to transform the sick patient into a healthy individual. Those activities that are pursued within the primary care center to transform sick individuals into well or healthy individuals can be termed the operating activities of the clinic because they differentiate it from other enterprises. A tank system is a system of activities plus the human and physical resources required to perform the activities. The old Medicare law and regulations appeared to perpetuate the omnipotent physician set of beliefs. There is a failure to recognize that a given system of activities can be implemented through varying mixes of manpower and technological resources. Because small communities cannot support the full range of services and frequently fail to attract physicians it is necessary for them to rely upon nurse practitioners or physician's assistants that are not directly supervised by physicians. Failure to provide Medicare reimbursement is a substantial impediment to their success in developing health services for the elderly and young. All reimbursements should be made on the basis of specific activity utilized for specific diagnostic categories. Reimbursement should not be made however, unless the clinic is carefully tied into surrounding medical resources. Further, in keeping with legal restrictions on the provision of medical services only those services should be reimbursed that are clearly within the legal framework of each state. Clearly, making available the reimbursement of nurse practitioners and physician's assistants in rural areas for Medicare services will greatly increase the total expenditure by Medicare. Yet, a change in regulation is necessary to eradicate the discrimination against rural vs. urban citizens. If cost containment is to be pursued it would be wise to promulgate regulations that discriminate on the basis of need rather than on the basis of geographic location. In summary, (1) this legislation could have a profound influence on health care delivery to rural legislation could have a protound innuence on health care derivery to rular areas throughout the country; (2) Reimbursements should be made for systems of activity performed by an enterprise rather than by a specific manpower assortment criteria; (3) Clinics qualifying should be carefully tied in to regional resources and preferably should be part of multi-community networks of services that are formally organized; (4) A certification process for nurse practitioners and physician's assistants should not be sub-

¹ Retained in files.

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stantially different than the certification process for physicians. However, all policies and procedures should make room for specific state legislation so as to permit variation from state to state until such time as federal legislation of medical care practice acts standardizes and unifies U.S. policy without respect to state boundaries.

> UNIVERSITY OF WISCONSIN MADISON. CENTER FOR HEALTH SCIENCES, Madison, Wis., March 22, 1977.

Mr. David Harf, Office of Senator Richard Clark, 404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: I am writing in regard to the Senate Rural Development

Subcommittee hearing on reimbursement of rural clinic services.

The characteristics of rural states like Wisconsin and Iowa are not amenable to conventional manpower solutions that attempt to place physicians in every town and hamlet. At the University of Wisconsin-Madison, Center for Health Sciences, we do not believe that such approaches are realistic or even desirable. Instead, we have adopted a more pragmatic view that focuses on transportation, technology assistance, changing community expectations for health services, and the development of methods to utilize medical and nonmedical personnel in a more effective and economical manner. Our concept employs physician extenders to improve the productivity of existing manpower as well as patient access and availability of basic health care. We currently have training programs for nurse practitioners and physician assistants in our Schools of Nursing and Allied Health Professions.

The health professional schools of the Health Sciences Center have a direct interest in Senator Clark's bill (S. 708), which would provide reimbursement for physician extenders under the Medicare program. While physician extenders offer great promise in improving the delivery of health services, their effective use and distribution are markedly constrained by the lack of stable financing. Unless third party reimbursement is obtained, the practice opportunities for physician assistants and nurse practitioners will be severely limited. The result will be a default to more expensive manpower models and

the American people will ultimately lose.

The cost-based approach for payment of physician extended services, as reflected in the bills of Senator Clark and Congressman Rostenkowski, is a preferred financing alternative. Cost-reimbursement will provide the financing necessary to support the operation of rural health clinics while avoiding more traditional open-ended payment schemes. Payment based on cost will also encourage the development of group arrangements which, including quality considerations, is preferable to solo practice. I hope that payment for physician extended services, however, will not be limited only to rural areas. Although it may be necessary to phase in reimbursement to allow time for evaluation and development of administrative procedures, inner-city manpower problems are equally critical and deserve similar priority.

In determining the eligibility of clinics for physician extender payments, emphasis should be placed on factors related to quality and effectiveness rather than structure. Each clinic should be organized as a nonprofit corporation and have provision for regular medical review of care provided. A formal agreement with an accredited hospital for patient transfer and back up support should be required. The affiliation agreement could provide for periodic review of the clinic operation by medical and hospital personnel who do not have a direct interest in the clinic. While this has disadvantages, it utilizes existing expertise without expanding the regulatory bureaucracy. Other requirements could be prescribed by the Secretary as necessary.

Recognition of eligible physician extenders should be broadly defined. Physician's assistants, as certified by the National Commission on Certification of Physician Assistants, and nurse practitioners, as certified by the American Nurses Association, are appropriate but eligibility should not be limited to these groups. Rather, the Secretary should be empowered to authorize reimbursement for the services of any physician extender (e.g., nurse midwife, pediatric nurse practitioner, etc.) who is certified by a similarly recognized national group.

Reimbursement for physician extenders will enable many rural areas to obtain basic health care that is presently not available and encourage the development of outreach services from existing health facilities. The Center for Health Sciences' Office of Rural Health, for example, will be able to assist small communities in planning and developing their own health program. This is currently an academic exercise since it is not possible for many rural areas to subsidize even basic health services. Similarly, I would expect many other institutions and medical groups to become actively involved in supporting rural-based physician extenders if an equitable reimbursement system is adopted.

I strongly endorse the public policy approach, as contained in Senator Clark's bill, which is designed to stimulate a private response to national

health needs.

Sincerely,

ROBERT E. COOKE, M.D., Vice Chancellor.

University of Arkansas for Medical Sciences, College of Medicine, Little Rock, Ark., March 15, 1977.

Senator Dick Clark, Chairman, Senate Rural Development Subcommittee, Washington, D.C.

DEAR SENATOR CLARK: I am pleased to have the opportunity to comment on your proposed Rural Health Clinic Bill. I firmly believe that there is a place for nurse practitioners and physicians' assistants in the rural health picture. For more than 30 years I have been involved in the practice of medicine in a rural community and have had the opportunity of serving on both state and national committees on Rural Health for Organized Medicine. During this period of time I have watched the development of Rural Health programs and agree with the statement that physicians generally will not practice in remote rural areas. They will tend to congregate in county seats, in trade areas, and in other areas where hospital and laboratory facilities are available. The tendency today is toward group practice. My own practice evolved in this manner prior to becoming a member of the faculty of the College of Medicine here in Arkansas.

During my years of practice the opportunity to use physician extenders did not present itself. In recent years I have witnessed and have heard about several success stories in the use of this type of health personnel and am convinced that if I were to go back into practice I would use physician extenders rather than partners or associates in the practice of medicine. This

leads me to the following recommendations:

1. Each nurse practitioner or physician assistant should have a period of training with a physician who will sponsor that individual for at least a period of six months. This would enable the extender to learn something of the practice characteristics of the physician to whom he or she will be

responsible.

2. The physician who sponsors the extender should be reimbursed based upon the income levels customary for that type of extender. This can be done on a graduated scale from total reimbursement to comparative reimbursement based upon productivity. At the end of the training process, the extender would be receiving a salary from his or her own earnings.

3. The fees earned by the extender should be approximately two-thirds of

that charged by the physician.

4. The physician should receive one-third for responsibilities incurred by sponsoring the extender. In other words, the total fee for service would be the same as that of the usual and customary charges of the physician.

5. The physician, thus continues to take full responsibility for the care of the patients, whether directly or indirectly. He will serve as the first line of

referral. He can then make further referrals if necessary.

6. The only type of certification necessary will be that provided by the responsible physician. Of course, the extender should have completed an approved course for either the nurse practitioner or physician assistant rating.

7. I believe that this type of legislation would assist many of our more remote small communities. It could serve to establish a network of health care that would serve all the people of our state and work no hardship upon the income or status of the practicing physicians in the state. I would envision an opportunity for all physicians to further their continuing education by permitting the use of the extenders in their own practices. The only limits placed upon this type of health care would be the availability of nurse practitioners and physicians' assistants and the provision of practice facilities.

This presentation may seem to be an over-simplification of the question but it does offer an opportunity for maintaining the responsibility of the individual physician. There would be less objection on the part of the medical

profession. I hope that these suggestions have some value.

Sincerely,

BEN N. SALTZMAN, M.D.,
Director, Rural Medical Development Programs.

THE UNIVERSITY OF NEBRASKA MEDICAL CENTER,
SCHOOL OF ALLIED HEALTH PROFESSIONS,
Omaha, Nebr., March 24, 1977.

Hon. DICK CLARK, U.S. Senate, 404 Russell Office Bldg., Washington, D.C.

DEAR SENATOR CLARK: I wish to thank you for the privilege of expressing my

views on S. 708.

The provision of health care to rural America by physician extenders is a relatively new concept but one that has had a success story throughout the United States. If the Medicare law which does not permit the supervising physician to be reimbursed for services provided by the physician extender is not amended, we will see one of the best alternatives in providing health care to our rural population come to a virtual halt.

This legislation directly affects approximately 32 physician assistants that are working in rural Nebraska. The amending of the Medicare law would open numerous positions with physicians across Nebraska who are now reluctant to hire physician assistants because the physician can not be reimbursed.

One of the most important issues in this bill is the definition of physician extender. I believe that this definition should be those individuals who are certified by the National Commission on Certification of Physician Assistants. Since these individuals will be providing the same type of medical services that are provided by physicians, there must be some type of examination to insure a minimum level of competency in knowledge and skills. An examination of this scope has been developed by the National Board of Medical Examiners and is administered by the National Commission on Certification of Physician Assistants. The NCCPA, who has a representative of the American Nursing Association as one of its Board of Directors, allows graduates of Nurse Practitioner Programs to sit for the National Certifying Examination. Specifically, the National Board of Medical Examiners in cooperation with the American Nursing Association and other groups have developed this competency exam and it seems reasonable that all individuals to be termed as physician extenders be required to pass this independent assessment of knowledge and skill.

The physician extender should be under the responsible supervision of a physician and not be allowed to become autonomous by having a collaborating

physician to whom they may refer patients.

Reimbursement should be made to the supervising physician for the services of the physician extender whether he provides care in the physician's office or in a satellite clinic. The reimbursement should be less than the physician's fee, but more than cost reimbursement to the physician to encourage the use of physician extenders.

On behalf of physician assistants and rural America, thank you for your efforts to change legislation to remove a major obstacle in the provision of

health services.

Sincerely,

STANFORD UNIVERSITY MEDICAL CENTER, Stanford, Calif., March 22, 1977.

SENATE RURAL DEVELOPMENT SUBCOMMITTEE. Offices of Senator Dick Clark, 404 Russell Bldg., Washington, D.C. (Attn. David Harf).

GENTLEMEN: Senate Bill 708 is unquestionably a step in the right direction, but I ask that you consider a broader approach to reimbursement for physician extenders. I believe such an approach to be justified on both economic and humanitarian grounds. The physician's assistant and the nurse practitioner constitute the most cost-effective, patient-oriented approach to the delivery of health care services since the disappearance of the country doctor.

It is ironic that Medi-Care and the Medicaid programs, designed to serve the under-served, should be the last to recognize physician extenders through their reimbursement policies. We are now facing a situation in which private-pay patients are receiving the benefits of professionals trained largely at government expense, and the medically indigent are not. The fear the physician extenders would be seen as the "poor folks' doctors" has now changed to a fear that the "poor folk" may never benefit from PEs.

Senate Bill 708 would provide the services of PEs in the communities that are isolated, medically under-served, rural, and have significant numbers of Medi-Care beneficiaries. All of these conditions except the ruralness, apply to nursing homes, wherever located. I think that services provided by PEs to

nursing home patients should be covered.

But I would not restrict it to those situations—the fact is that the elderly who live in our cities in "independent living arrangements" are isolated by physical infirmities and transportation problems. We cannot expect highlytrained physicians to go to the patient, but PEs can and do make house calls. Medi-Care reimbursement could provide essential health maintenance and pre-

clude institutionalization of many elderly people.

While it may seem contrary to good sense to ask the PE-delivered services be reimbursed at the same scale as physician-delivered services, I believe that such a policy is necessary. A physician/extender practice has, except for salaries, much the same overhead costs as a two-physician practice. The space, supplies, support personnel, and paper-work costs are virtually identical. The physician must spend some time in supervision of the PE, and the PE is not usually as efficient as a physician. The lower salary of the PE is largely off-set by these considerations.

I think that any inflationary tendency of a full reimbursement policy will be off-set by improved ambulatory care. For the present, I believe that the increased access to ambulatory care in places where it is desperately needed, and long-run increases in practice efficiency justify fiscal encouragement of the

use of physician extenders.

The California Medicaid program is now amending its regulations to allow full indirect reimbursement to physician's assistants, nurse practitioners, and nurse mid-wives. Medi-Cal arrived at this position after long, careful scrutiny of the costs and benefits to the program and to the patients. There is strong support for this move from the California Department of Health, the legislature, the medical profession, and the Board of Medical Quality Assurance.

I urge you to make the services of these health care practitioners available to people who really need them. It will be a move toward rationalizing health

Thank you for your time and attention.

Sincerely,

GEORGE F. ARMSTRONG, Field Services Coordinator.

THE UNIVERSITY OF NORTH DAKOTA, Grand Forks, March 24, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: In response to your request for written testimony regarding bill S. 708, we are pleased to submit the enclosed.

We will be very interested to learn of the outcome of both the Subcommittee hearing and the bill itself.

Thank you for the opportunity to express our views. We hope they will be of assistance in your deliberations.

Sincerely,

GARY F. DUNN,
Associate Dean for Planning and Development.
JUDY DEMERS, R.N., M. Ed.
Director, Family Nurse Practitioner Program.

TESTIMONY REGARDING S. 708

The problem of distribution of health manpower as it relates to rural areas cannot be overcome by insisting that the delivery of all manner of health care be done solely by physicians. Despite repeated documentation of the value and need of permitting a variety of health care services to be offered by well-trained physician extenders, the combination of archaic medical practice acts and reactionary reimbursement practices have mitigated against the development of non-traditional programs designed to alleviate the problems of access to care for rural isolated experiences.

Problems relating to legal recognition and economics based on a limited patient population necessary to sustain a traditional medical practice will prevail, despite this or any attempts at solution. However, once it becomes possible for other than physicians to practice and be reimbursed for their services, the political community will be more able to eliminate the legal restrictions placed upon the delivery of essential and effective non-physician care.

In view of these considerations, therefore, we find ourselves in support of

S. 708.

We feel that the manner of reimbursement for the services provided by physician extenders should parallel that now used for physicians—on the established fee-for-service basis. We favor 100% reimbursement at this time, but we are willing to modify this stance if evidence from studies such as the extensive Social Security investigation now in progress indicate that physician extender practices are economically feasible at less than 100% reimbursement. We would favor lower percentage rates of reimbursement in an effort to lower the cost of quality health care.

We are in full agreement with the eight criteria for clinics set forth in the

Congressional Record of Thursday, February 10, 1977, on page two:

The term "rural health clinic means a facility which-

(A) Is primarily engaged in providing rural health clinic services;

(B) Has an arrangement with one or more physicians under which provision is made for the regular review by such physicians of all medical services

furnished by physician extenders:

(C) Provides for the preparation by the supervising physicians and physician extenders of medical orders for care and treatment of clinic patients, and the availability of such physicians for such referral and consultation for patients as is necessary, and for advice and assistance in the management of medical emergencies;

(D) Maintains clinical records on all patients;

(E) Has arrangements with one or more hospitals for the referral or admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(F) Has written policies to govern the management of the clinic and all

the services it provides;

(G) Has appropriate procedures or arrangements, in compliance with applicable State and Federal law, for storing, administering, and dispensing drugs and biologicals; and

(H) Has appropriate procedures for utilization review.

We feel that these requirements will assure an integrated system comprised of physician, physician extender, clinic, and hospital and maintain the quality of health care delivered. In view of the differences in state laws and practice styles of supervising physicians, we approve of the flexibility of the guidelines in allowing for

differing methods of implementation.

Providers whose services would be reimbursable under this legislation should be certified either as Assistants to the Primary Care Physician by the National Certifying Commission, or as Adult/Family Nurse Practitioners by the American Nurses Association, and should meet local and state requirements for practice.

Since the National Boards are given only once a year and the ANA examination is given only twice yearly, many students cannot take the examination in time to become certified by the time of graduation. We therefore recommend that some provision be made for such graduates to be reimbursed on a con-

ditional basis pending their national certification.

We would also like to see the law be flexible enough to accommodate any new certification programs that may be developed by any of the national specialty boards for assistants in their specialties, such as orthopedics, sur-

gery, and so forth.

We feel that this piece of legislation is definitely necessary and that it will greatly benefit rural America. We do have two major concerns. First, we would like it clarified in no uncertain terms that this new law would remove the stipulation that the physician must personally see the patient in order for reimbursement to be made for services rendered by physician extenders.

It is a common misconception that reimbursement can be made for such services if a physician is on site. (See Mr. Leaby's statement, Congressional Record, February 10, 1977, page 3.) In actuality, it can only be made if the physician actually examines the patient, in spite of any services that may have already been performed by the extender. This repetition is obviously an inefficient use of time and manpower, and a frequent deterrent to the use of physician extenders by physicians who could well use their assistance. We feel that the availability of the physician for consultation and supervision should be sufficient warranty for the reimbursement of those services he may choose to delegate to the physician extender.

Our second concern involves the practitioner such as the public health nurse trained as a physician extender and providing services in both rural and non-rural settings. It seems unjustifiable that services should be reimbursable when performed in one setting, and yet not when performed in another.

We realize that the primary purpose of this bill is to provide reimbursement for physician extenders who are working in rural sites remote from their supervising physician. We applaud this effort and give it our full support. At the same time, we hope the Committee will examine our concerns regarding inconsistencies in reimbursement in situations with a physician onsite and away, and in situations rural and non-rural.

DARTMOUTH MEDICAL SCHOOL, DEPARTMENT OF COMMUNITY MEDICINE, Hanover, N.H. March 22, 1977.

David Harf,
Office of Senator Dick Clark,
404 Russell Bldg., Washington, D.C.

DEAR SENATOR CLARK: This letter is in response to your March 7 letter regarding S-708, a bill to permit Medicare reimbursement to rural health clinics for primary health services. I am a Family Nurse Practitioner and I strongly support this bill.

I believe that all Third Party Reimbursement plans are the only viable alternatives that will support community clinics employing nurse practitioners. I would like to see a focus on services and system reimbursement, not indi-

vidual provider reimbursement.

New Hampshire has a rural population of 43.6 per cent according to the 1970 census poll. There are many small towns, particularly in northern New Hampshire who do not have physicians in residence. Recent federal legislation HR 5546 provides for a \$15,000 loan to small rural communities to set up satellite clinics that use nurse practitioner services.

I feel that the American Nurses Association Certification Examinations for nurse practitioners should be mandatory. The nurses who pass the examinations should be reimbursed for their services.

Thank you for this opportunity to express my opinions.

Sincerely,

Sandy Zubkoff, FNP,
Nurse Coordinator for the Development of
a Nurse Practitioner Training Program.

STATEMENT OF L. A. CRANDALL, PH. D., ASSISTANT RESEARCH SCIENTIST; W. J. COGGINS, M.D., PROFESSOR AND DIVISION OF RURAL HEALTH CHIEF; AND R.C. REYNOLDS, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF COMMUNITY HEALTH AND FAMILY MEDICINE, UNIVERSITY OF FLORIDA

We are pleased to have this opportunity to testify on S. 708, a bill to permit Medicare reimbursement for physician extender services provided by rural health facilities. Because our department operates both a Division of Physician's Assistant Training and a Division of Rural Health which provides a broad range of health services for three medically underserved rural counties, we reviewed this bill with great interest. We would like to offer comments on several issues regarding the effects of this bill on health care delivery in rural areas and the mechanisms by which this care will be financed and delivered.

MEDICARE REIMBURSEMENT IN RURAL AREAS

Part B of the Medicare, the supplementary medical insurance program, has consistently reimbursed the health care costs of aged residents in rural America at a lower rate than those of their urban counterparts. In part, this difference may be due to the greater use of physician extenders in rural clinics. The clinics cannot currently be reimbursed by Medicare for services performed by physician extenders unless a physician is physically present while services are being rendered. Due to the shortage of physicians in rural areas, this is often impossible and the cost of the service must be billed to the patient or absorbed by the clinic. By passing S. 708 the Congress will remove this barrier to primary care for the rural aged, and improve the financial situation of many

physician extender staffed rural clinics.

We would also like to note that the current Medicare policy of reimbursing usual and customary charges for physicians' services is a major cause of the inequities between rural and urban reimbursement levels. Identical services, provided by a physician, are presently reimbursed at a higher rate in urban areas than in rural areas. Indeed, the reimbursement rate in rural areas may be lower than the costs associated with the provision of services. Thus, we endorse the reimbursement mechanism contained in S. 708 to the extent that the rural health clinic is allowed to recover the true costs associated with the delivery of services, including an appropriate portion of the costs of maintain ing the clinic and hiring ancillary personnel required for the practice, the costs of providing physician supervision in satellite clinics and other costs necessary to the provision of services by physician extenders. In other words, the reimbursement formula associated with this bill should recognize all of the costs associated with the delivery of rural primary care services by physician extenders.

Finally, we strongly support the mechanism proposed in the bill by which the clinic rather than the individual physician extender will be reimbursed for the services provided.

SUPERVISION OF PHYSICIAN EXTENDERS

S. 708 should clearly state that the reimbursement of services applies only to those services provided under the responsible supervision of a licensed physician (or licensed physicians). At present, mention of this supervision in the bill seems to be more implicit than explicit. The form of this supervision should include review by the physician of all services provided by the physician extender. However, other types of supervision may also be exercised when appropriate. These other forms of supervision may vary depending on the site where the services are rendered (e.g., clinics, satellite clinics, etc.) and on the

availability of physicians for direct consultation or consultation by telephone. We feel that the proposed legislation implicitly defines responsible supervision as "regular review of all medical services provided by physician extenders." We suggest that a more explicit definition of the responsible supervision of physician extenders should be included in the legislation, or in the regulations developed in implementing it. These regulations should recognize that the present shortage of primary care physicians in this country may be transitory, as a result of the implementation of the Health Professions Educational Assistance Act of 1976 and the development of new programs in primary care in medical schools, an increased supply of physicians trained in primary care seems likely to exist within the next decade. Although these physicians may not locate their practices in isolated rural communities it seems likely that many will locate in cities with fewer than 50,000 people, and will therefore be available for supervision of physician extenders in rural clinics. Therefore, S. 708 should not assume that a shortage of physicians to supervise physician extenders in rural clinics will persist.

Finally, a different type of supervision of physician extenders may be exercised by the development of specific policies concerning their practice. For example, we would like to suggest that the adoption of a controlled formulary for physician extenders be considered. This formulary could be developed in the rural clinic as a part of "the written policies to govern the management of services that it provides," or as a part of "appropriate procedures or arrangements . . . for storing, administering, and dispensing drugs and biologicals." Supervision over prescribing patterns could also be exercised by developing a standard formulary at the federal level and reimbursing only the items contained in this formulary. Regardless of the mechanism employed, the selection of drugs for prescription by a physician extender is an area in which

responsible supervision is especially important.

EVALUATION OF THE LAW'S EFFECTS ON HEALTH CARE DELIVERY

Experiences with the Medicare and Medicaid program have shown that legislation often produces changes in the health care delivery system which are unanticipated. In many cases these changes are consistent with the purposes of the legislation. However, the unanticipated consequences of legislative action are not always benign, and can result in new problems or inequities in health care delivery (e.g., rapid increases in costs, new barriers to the use of services pool allocation of resources). Therefore we urge that this bill contain a requirement that, after an appropriate period of time has passed, the Department of Health, Education and Welfare will gather administrative data, and such other data as are deemed necessary to evaluate the effects of this legislation in terms of a) the intended consequences of the legislation (as stated by Senators Clark and Leahy in the Congressional Record, Vol. 123, No. 125) and b) the unanticipated consequences of the legislation. This evaluation of the effects of the legislation should be required for continuation of the reimbursement of physician extenders in rural clinics beyond an initial three to five year period.

OTHER COMMENTS

We strongly support the current definition of a physician extender in S. 708 with reference to its mention of certification by an appropriate agency. We note that this definition differs from that of the bills currently being considered in the House of Representatives. With particular reference to physicians assistants we submit that they are most correctly defined as "individuals who have completed an educational program for physician assistants accredited by the Council on Medical Education or other recognized accrediting agency and/or are holders of valid certificates from the National Commission on Certification of Physician's Assistants."

We also wish to note that the present wording of S. 708 includes, as a part of the definition of a rural health clinic, the requirement that clinic "(E) has arrangements with one or more hospitals for the referral or admission of patients . . .;". We submit that the following wording would be more correct: "(E) has arrangements with one or more physicians with hospital privileges

for the referral or admission to hospital of patients . . .;".

We would like to extend our thanks to the Committee on Agriculture and Forestry and in particular to Senators Clark and Leahy for offering us the

opportunity to testify on this bill. We feel that S. 708 will increase the accessibility of primary health care for many aged Americans living in rural areas and will contribute significantly to the economic survival of many rural health clinics.

THE UNIVERSITY OF NEBRASKA MEDICAL CENTER, School of Allied Health Professions, Omaha, Nebr., March 22, 1977.

Hon. DICK CLARK, U.S. Senate,

404 Russell Office Bldg., Washington, D.C.

Dear Senator Clark: Thank you for the opportunity to express my thoughts about S. 708 pertaining to medicare reimbursement of physician extenders.

If the physician's extender concept is to survive then we must have an amendment to the medicare law that will permit the supervising physician to be reimbursed for the services of his assistant.

Some points are important:

1. The definition of assistants should be limited to those individuals who are certified by the National Commission on Certification of Assistants to the Primary Care Physician. The nurse practitioners are eligible to take the certifying examination and I think all assistants assuming such an important role should meet the same high standards established by the Commission.

2. Each assistant should be under the "responsible" supervision of a physician. To permit the extender to only a "cooperating" physician will result in the extender being an independent practitioner and I believe this is wrong

and dangerous.

3. Reimbursement should be on a fee-for-service at 80% of the physician's fee. Society should realize some cost benefits. It takes a lot less money and time to train a physician assistant.

4. Reimbursement should be permitted for physician supervised clinics as well as satellite clinics, The reimbursement should be to the physician that

employs the PA, not to the PA.

At the present time in Nebraska, about 20 to 25 clinics in towns of less than 2,000 population would benefit from the proposed change to the medicare-law. My informed opinion is that at least 30 to 50 additional clinics would benefit if the law was changed. There are many, many physicians in Nebraska that desperately need help and would hire a PA if there could be reimbursement for the services PAs render.

Thank you again for this opportunity to express my views and for all of

your hard work in trying to correct a serious inequity.

Sincerely,

Jesse C. Edwards, Assistant Director.

THE UNIVERSITY OF VERMONT,
DIVISION OF HEALTH SCIENCES,
Burlington, Vt., March 22, 1977.

Hon, Patrick J. Leahy, 1203 Dirksen Office Bldg., Capitol Hill, Washington, D.C.

DEAR SENATOR LEAHY: As you know, the University of Vermont College of Medicine is very much concerned about the adequacy of rural health care. Several of our programs, most notably, our Family Practice Program, have been designed to attempt to deal with this problem. In addition, our faculty has participated in some of the experimental projects related to providing health care to rural populations, especially the project in Grand Isle, Vermont.

It is clear that all of the rural health needs cannot be met by physicians for a variety of reasons. Therefore, I do support strongly measures to assist in the appropriate utilization of other health professionals to provide needed care. I am certain that the legislation that you propose would aid such other health professionals. However, I do not feel competent to discuss in detail

mechanisms for reimbursement, quality control, certification, and physician supervision for these health professionals. I do think that the details of such matters can best be suggested by individuals of more direct experience than myself. However, I do think all of these are extremely important issues

that must be addressed carefully before legislation is enacted.

I know that Dr. Henry Tufo of our faculty has written to you in the past expressing his opinions on these matters. Since he has participated directly in rural health projects in the past, I would value his suggestions highly. In addition, Dr. Edward Friedman, Chairman of our Department of Family Practice, would be another source of valuable information for your Committee.

Thank you for giving me the opportunity to comment upon this pending legislation. If there is anything further that I can do to furnish you with

information, please do not hesitate to contact me.

Sincerely,

WILLIAM H. LUGINBUHL, M.D., Dean.

MEDICAL COLLEGE OF OHIO AT TOLEDO,
DEPARTMENT OF COMMUNITY MEDICINE,
Toledo, Ohio, March 24, 1977.

DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: Regarding your communication of March 7, 1977, I wish to express my appreciation for the opportunity to comment on S. 708 for the hearings by the Senate Rural Development Subcommittee. I will respond to your four questions and then offer some additional comments that may be

of use in the Subcommittee deliberations.

I strongly support the concept of this legislation (S. 708), because financial disincentives to health service development are an acute problem in rural areas. The provision of reimbursement for physician extenders (as defined in S. 708) would decrease the financial risk to small communities of expanding limited physician services or experimenting with new forms of delivering primary care services. Such experimentation is needed in rural communities. The assurance of reimbursement for the above services should encourage the development of new satellite clinics or the expansion of existing programs.

The method of cost based reimbursement specified in S. 708 is preferred, because new or innovative programs need this type of predictable support to insure their financial stability in the early period of growth. Upon the establishment of financial stability it may be that capitation payment experiments should be initiated in some clinics to determine whether increased productivity is encouraged by the incentive to expand the case load. I am not in favor of

traditional fee-for-service reimbursement for these delivery systems.

The eight structural requirements for Rural Health Clinics as specified in the additions to section 1861 - Subsection (aa)(2) (A)-(H) are adequate

with two exceptions.

(1) Item $(\bar{\mathbf{E}})$ should state that arrangements should be made with one or more hospitals for referral and admission. The possibility of referral but not admission privileges could discourage continuity of care in regionalized systems of hospital support. I realize that there are practical problems at the local level with this type of requirement, but we should not encourage potential losses in continuity.

(2) I would recommend that item (F) include a statement requiring *local* consumer input to the established "written policies" governing management

of the rural clinics.

I strongly support national certification of physician extenders. Such nationwide establishment standards should encourage greater inter-state mobility of these new providers thereby increasing the potential manpower pool available to rural communities.

The language defining appropriate geographic areas within which rural health clinics function (Section 1861, Subsection (aa) (3)) is confusing. Is it implied that a rural health clinic functioning under the requirements

of this legislation but serving a rural area which is not defined as medically underserved would not be eligible for medicare reimbursement for services of its physician extenders? If so, the language may discriminate against some rural clinics in need of this type of financial support. In addition, it would create unnecessary administrative confusion during the reimbursement process. To a considerable extent, financial problems of rural health clinics are independent of whether their service area is underserved. Simplification of the definition of rural areas to eliminate the medically underserved provision

would be preferred. I would like to call your attention to another provision of the Medicare regulations which may affect S. 708. It has come to my attention that certain Medicare regulations would require that a clinic serve a minimum number of Medicare patients (250) and submit a minimum level of Medicare billings (\$15,000) each year in order to receive cost based reimbursement (press message by the Appalachian Regional Commission, January 17, 1977). It is possible that such provisions might limit the effectiveness of S. 708 in providing financial support to developing rural health delivery systems (especially during the start-up stage). The above requirements should be pre-empted by S. 708.

I hope my comments will be helpful to you and to the Subcommittee. If

you have any questions, don't hesitate to contact me.
Thank you for your attention.

Sincerely,

C. WILLIAM BLAIR, M.P.H., Assistant Professor of Community Medicine.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES, Washington, D.C., March 25, 1977.

Hon. DICK CLARK,

Chairman, U.S. Senate Rural Health Development Subcommittee, U.S. Senate Committee on Agriculture and Forestry, Washington, D.C.

DEAR SENATOR CLARK: The Association of American Medical Colleges (AAMC), representing 117 United States medical schools, 400 teaching hospitals, and 56 academic medical societies, is pleased to offer this statement of support of the objectives and general principles incorporated in your bill S. 708 to permit Medicare reimbursement to rural health clinics for primary health services. The Association has long been concerned with the problems related to the availablity and accessibility of primary health care for the medically underserved segments of our society, particularly those located in remote rural areas and in certain pockets within our inner-cities. We have long recognized that the development of health systems networks, which make heavy use of physician extenders under appropriate physician supervision, may well be the means for improving the availability and accessibility of quality health services for these underserved population groups. Our commitment to this strategy is exhibited by the fact that 75% of the nation's academic medical centers now sponsor programs for the education and training of "physician extenders" (i.e., physicians' assistants, health associates, MEDEX, and nurse practitioners) throughout the United States.

The AAMC also is cognizant of the problems associated with adequate reimbursement under Medicare for those services provided by non-physician health care providers in rural health clinics. Certainly, unless appropriate means can be developed for reimbursement of such services under Federally sponsored health programs, much of the training and education effort, supported to a large extent through public funds in the national interest, will have gone for naught. We believe that those provisions in S. 708 which stipulate direct payments to rural health clinics are appropriate and go far toward ameliorating the existing reimbursement difficulties concerning the use of physician extenders in the rural health setting. However, we urge that this bill likewise include those clinics located in appropriately designated

inner-city underserved areas.

The AAMC is concerned as well, with the issue of quality of care in these clinics. We believe that the conditions stipulated in your bill for physician

supervision and responsibility and those provisions requiring quality control and utilization review are far superior to those included in the companion House Bill, H.R. 2405. The presence of these provisions in S. 708 has greatly enhanced our desire to support this legislation. We further believe that regulations can be developed by the Secretary of HEW, under the provisions of this act, so as to reasonably assure quality of services and believe, as well, that scrutiny by the Inspector General, DHEW, if done adequately, can go far toward assuring against the creation of so-called "Medicaid Mills." We note that S. 708 provides that nothing in the Act's amendments shall be construed as superceding any State law regarding the use of physician extenders and the provision of health services and we support this provision fully. In addition, we note our agreement with the bill's provisions regarding physician extender certification and legal authorization to provide services. In closing, there are two additional comments which we would like to make. Firstly, since the intent of this legislation is reform of the Medicare program, we believe that to be effective S. 708 must remain consistent with restablished Medicare principles. Therefore we advecte that reimburses

In closing, there are two additional comments which we would like to make. Firstly, since the intent of this legislation is reform of the Medicare program, we believe that to be effective S. 708 must remain consistent with established Medicare principles. Therefore, we advocate that reimbursement payments for services rendered by rural health clinics be strictly made on the basis of costs reasonably related to providing such services. We oppose the concept that would give the HEW Secretary the discretionary authority to approve alternative arrangements for reimbursements. Secondly, we support the general contention that services provided by physician extenders in situations involving on-site or direct physician supervision should likewise be reimbursed under the Medicare program. Such reimbursements, we believe, should go directly to the supervising physician or to the clinic provided that quality assurance and utilization review programs are in place. We suggest that these considerations be incorporated either into the present bill, S. 708, or into future legislation.

Thank you for this opportunity to express our views and recommendations

regarding S. 708.

Sincerely,

John F. Sherman, Ph. D. Vice President.

WAKE FOREST UNIVERSITY, BOWMAN GRAY SCHOOL OF MEDICINE, Winston-Salem, N.C., March 21, 1977.

Hon. Patrick Leahy, U.S. Senator, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR SIR: It is a privilege to respond to your invitation to provide written testimony for the hearing on the subject of Medicare reimbursement of rural health clinic services.

The testimony below is derived from my five and one-half years of association with this training program and the performance of its graduates. It is not to be assumed that my statements represent the position of this institution or of the Association of Physician Assistant Programs.

STATEMENT OF REIMBURSEMENTS OF PHYSICIAN EXTENDERS BY MEDICARE FOR MEDICAL CARE

- 1. Physician extenders (i.e., physician assistants, MEDEX, and nurse practitioners) can, and do, improve the accessibility of primary care. The services of physician extenders are a particularly valuable addition to rural medical care.
- 2. With regard to practice sites, the rural clinics are only one example of the clinical facilities which can and do utilize physician extenders to increase the amount and quality of medical care being provided. Reimbursement under Medicare should not be restricted to care provided in rural health clinics, but should be made available for care provided in other medical facilities, including the offices of private physicians, as well.
- 3. The personnel who are systematically and continually providing medical care in whatever clinical facility should be limited to those persons who are

suitably trained and/or certified to provide such care and who are legally

practicing under the laws of the state in which the care is provided.

4. All patients deserve assurance of getting the best available care. As the most knowledgeable and best trained of all health care professionals, the medical doctors who are licensed to practice in each state should be responsible for all medical care legally provided in that state. Reimbursement by Medicare should be provided only for those services of physician extenders which are provided under the supervision, either remote or on-site, of such responsible physicians. To provide Medicare reimbursement in any other situation would be to open medical practice to less well qualified practitioners at the expense, via Medicare reimbursement, of the American taxpayer.

5. A law to provide reimbursement under the terms stated above is due. H.E.W. has supported the training of capable physician extenders with millions of dollars. To continue to hamper the use of these trained clinicians by not providing reimbursement by Medicare for their services is to defer the provision of more medical care of superior quality that would otherwise be available to many of the medically deprived people of this nation.

Thank you for this opportunity to provide this testimony.

Respectfully submitted.

JIMMIE L. PHARRIS, Ph. D., Director, Physician Assistant Program.

COMPREHENSIVE CARE FOR CHILDREN AND YOUTH, UNIVERSITY OF VIRGINIA MEDICAL CENTER. Charlottesville, Va., March 22, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: I have read with interest the provisions of Senate Bill S. 708 described in the Congressional Record of Thursday, February 10, 1977. It is my understanding that on Tuesday, March 29, the Senate Rural Development Sub-Committee will conduct a hearing with regard to this bill and,

therefore, I wish to make the following comments.

At the present time, I am both a provider and developer of health care services in the rural area of Virginia surrounding the City of Charlottesville. The catchment area I serve is that of Virginia Planning District #10 and within that, primarily, the Counties of Albemarle, Louisa, Greene and the City of Charlottesville. There is in this area approximately 100,000 people, 40,000 of those in the 15 square miles of the City of Charlottesville and the remaining 60,000 or 70,000 in the almost 1,500 square miles of the counties. There is very limited public transportation within the City of Charlottesville and the best that can be said for the counties is that public transportation is either unavailable or prohibitively expensive to the majority of the population of these rural areas. In the last ten years not only have physicians been reluctant to establish practices out of the City of Charlottesville, but through attrition, the surrounding areas are either doctorless or have a sufficiently low physician-population ratio to be designated as medically underserved areas. In that period of time, too, the University of Virginia Emergency Room has become the private physician for a large majority of County residents. This is inconvenient for the population and is therefore, used by them inappropriately in the course of an illness, with many people presenting to the University only in the terminal stages of their illness. In an effort to cope with the aforementioned problems the University of Virginia has embarked upon several programs designed to extend care into the rural areas.

Approximately ten years ago, the Department of Pediatrics established the first Children and Youth Program in the State of Virginia and, a major element of this program, was the establishment of satellite clinics in several areas of Albemarle County. About two years ago this was extended into Louisa County. These satellites at the present time, are operating only one day per week and are serving only children. Most recently, we joined with the Department of Family Practice to embark upon a Health Underserved Rural Areas program funded through the Department of Health, Education and Welfare. This program is designed to provide primary care to all people in

underserved areas and we are attempting to do this by expanding several of our former C&Y satellites to include comprehensive family care and also to

extend our operation into Greene County.

In order to provide this care on a cost-effective basis, we must utilize the services of physician extenders, notably the Family Nurse Practitioners and will have on-site physician coverage only two full days a week in each site; this to allow our physicians to rotate from site to site, seeing the most problematic patients and, thereby, spreading the cost of care among the three

The State of Virginia has been most cooperative with us in developing this program and has agreed to allow for reimbursement of the Nurse Practitioners with only the indirect supervision of physicians as a usual method of operation. Naturally, we will be expected to review the work of the Nurse Practitioners periodically to authorize their prescriptions and many of the more difficult diagnostic procedures. All of this has been built into the program we have developed. We have been unsuccessful at the present time in working out any arrangements for reimbursement through Medicare for the adult patients whom we will see. The reason given for the refusal to authorize payment is that we will not have a physician on-site twenty-four hours a day, seven days a week. On the other hand, were we to do this, we would most assuredly drive up the cost of care to where it would be prohibitive both for the people whom we serve and for the third parties who will reimburse us for the care of some of those people. As the Congressional Record points out, Nurse Practitioners have been shown in numerous studies throughout the Country to provide high quality, cost-effective care and we feel that the system we have devised could well serve as a model for physicians who wish to practice in rural areas but realize themselves, that each small rural community may not, in itself, be able to support the services of a full-time physician.

As we sit now to review the progress we have made thus far and try to anticipate the problems that lie ahead, we can see quite clearly that this experiment in providing rural care will never be successful unless or until all third party payers allow for the services of Nurse Practitioners. We feel that as long as the Nurse Practitioners are adequately trained graduates of certified programs and have successfully completed the certifying examinations; as long as they are given established and workable protocols to follow, as long as they are able to communicate with physicians at a moment's notice and as long as there is periodic on-site supervision by the physicians as well as physician review of the Nurse Practitioners' work, that the Nurse Practitioners should be reimbursed at the same rate as the physician would be. With respect to this I have no objections to or strong feelings for fee-forservice payments, capitation grants or any other imaginable reimbursement

mechanism.

I sincerely hope that you will be successful in securing the passage of this bill as I believe it to be an important piece of legislation in terms of improving the health care of the people of rural America. I would be happy to answer any further questions you may have in this regard.

Thank you very much for your solicitation of comments.

Sincerely,

JOSEPH R. ZANGA, M.D., Assistant Professor.

UNIVERSITY OF CALIFORNIA, DAVIS, DIVISION OF COMMUNITY AND POSTGRADUATE MEDICINE, Sacramento, Calif., March 22, 1977.

Hon. DICK CLARK,

Chairman, Senate Rural Development Subcommittee, Hon. Patrick Leahy, 404 Russell Bldg., Washington, D.C.

DEAR SENATORS CLARK AND LEAHY: On behalf of the University of California, Davis, Family Nurse Practitioner Program, I thank you for the opportunity to present our views at the hearing on S. 708.

We in the University of California, Davis, Program have as our Core Mission the improvement of the quality and distribution of primary care to the people of California, particularly in rural and underserved areas.

Since our beginning in 1970, we have trained over 280 graduates, 240 of whom are practicing in 45 underserved counties in California. We have worked closely with our state's Medi-Cal (California Medicaid) Division to devise regulations for reimbursement to physician assistants and nurse practitioners, as we feel this is crucial to the mission we have set out to accomplish—getting primary care providers to underserved (particularly rural) areas.

Likewise, with respect to Medicare, we would strongly urge your support of legislation such as S. 708 to amend the Social Security Act and give the long overdue recognition and authority to all qualified primary care providers; whether physicians, physician assistants, or nurse practitioners; to be reim-

bursed for their services.

We find the current situation of not allowing reimbursement not only ironic and inconsistent, in light of the large number of federally funded nurse practitioner and physician assistant training programs, but also wasteful of the talent of trained professionals and detrimental to the interests of the many

Medicare recipients in this country.

We want to stress that physician assistants and nurse practitioners have been shown to be an economically viable way of assuring access to high quality primary health care to medically indigent people and underserved areas, Study after study attests to the quality of care delivered by these non-physician practitioners working as a team with a physician. Training programs of these practitioners have been quite successful in placing their graduates in underserved areas, and some of the most imaginative and effective efforts at such placements have been used by these programs.

The most immediate effect of the Social Security Act, as currently written, is the denial of health care services by non-physician providers to the many elderly Medicare patients who are in extended-care facilities, confined to their homes, or who live in rural areas with no access to physicians. Under present law, health care for these people must be provided by the physician or no one.

Too often it is no one.

The physician/non-physician practitioner team offers several advantages to the patients. The most obvious is increased access to health care simply by the presence of another practitioner. This increased access is accompanied by a more efficient utilization of the physician's time, skills, and training. In addition, physician assistants and nurse practitioners are taught to be aware of psychosocial and psychosomatic facets of illness. The final reassurance for the patient is that the physician provides consultations, as well as more advanced skills when needed. As a result of these conditions, patient acceptance of non-physician practitioners has been excellent.

From the point of view of the Social Security Administration, we believe these practitioners will help to stabilize the cost of health care over the long run, and practices which utilize them will be able to resist better the inevitable rise in fees because of the cost effectivness of team practice. You should also consider that the physician assistants and nurse practitioners work primarily in ambulatory care settings. It has been amply demonstrated that sufficient and timely ambulatory and outpatient care can decrease the need for later

more costly hospital care.

We would support the reimbursement of qualified non-physician primary health care providers. By that, we mean physician assistants licensed by their state and nurse practitioners that are graduates of programs which meet the

guidelines for federal funding.

We do not support the idea of separate provider numbers. Rather, we feel that all services should be billed under a clinic or physician provider number to insure that physician assistants and nurse practitioners function with physicians as a true health care team. This implies supervision of the non-physician providers by the physicians using any or all of the following means:

(1) Protocols and standardized procedures for diagnosis and treatment, (2) direct on-site supervision, or (3) telephonic consultation for those physician assistants and nurse practitioners in wasting the skills of proven health care sician.

We would urge the use of problem oriented medical records and the review of all charts by the physician supervisor on at least a weekly basis. Access to consultants and a hospital for referral are also essential. This would assure

the quality of care toward which we are all strivir z.

Finally, we feel very strongly that non-physician primary health care providers should be reimbursed by Medicare for the services they deliver at a rate equal to that allowed for comparable services provided by doctors. Lower reimbursement will affect patient acceptance of these practitioners as they will be seen by patients as providing second-class medicine. Lower reimbursement will also discourage their employment in areas which need them most.

ment will also discourage their employment in areas which need them most. In summary, the Social Security Act, by denying reimbursement to physician assistants and nurse practitioners in wasting the skills of proven health care providers, seriously jeopardizing their utilization, and depriving needy persons throughout America of access to health care. We strongly support legislation to amend the Social Security Act and allow for reimbursement of physician assistants and nurse practitioners working with physicians to deliver primary health care services to Medicare patients.

Thank you, again, for this opportunity.

Sincerely,

JANE HALPERN, M.D., Co-Associate Director.

WICHITA STATE UNIVERSITY, Wichita, Kans., March 16, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR SENATOR CLARK: Reference is made to your March 7, 1977 letter re-

quest for written testimony relating to S.B. 708.

Wichita State University as an institution strongly supports the viability of the philosophical concept of the physician's assistant. I do not, however, believe that it is in the public interest to indirectly support the evolution of rural health clinics conducted by unsupervised physician's extenders be they nurse practitioners or physician's assistants.

It is recognized that the maldistribution of physicians in states such as Kansas imposes a very real dilemma for those living in rural areas. However, to condone the practice of medicine by those not fully qualified to make sustained, independent medical judgments would seemingly support the notion that this country believes that only the city dweller deserves first rate health

care.

We believe as do you, Senator Clark, that Title XVIII of the Social Security Act must be amended to provide payment for services rendered by physician extenders in rural health clinics. Our concern is that S.B. 708 does not relate to the necessity for physician supervision. There is general concurrence that these health professionals must be the responsibility of a licensed physician; such a relationship cannot exist without clear delineation of how the physician will exercise his/her prerogative.

Adequate supervision need not necessarily require the physical presence of the physician on an hour-to-hour basis. It may be indirect, retrospective or anticipatory; regardless of the form, it must be clearly understood by the professionals involved prior to patient contact to avoid legal consequences

fessionals involved prior to patient contact to avoid legal consequences.

It is my opinion Senator Clark that your bill would be strengthened if it included provision for the reimbursement of physician extenders practicing in

physician directed rural health clinics.

Sincerely,

D. CRAMER REED, M.D., Vice President, Health-Education.

UNIVERSITY OF UTAH MEDICAL CENTER,
DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE,
Salt Lake City, Utah, March 17, 1977.

DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR Mr. HARF: We have received notification of hearings on Senate Bill 708, to permit Medicare reimbursement to rural health clinics for primary

health services delivered by nurse practitioners and physician assistants. The discussion in the Congressional Record showed your awareness of the problems involved in delivering quality health care to remote communities in the United States.

The primary objective of our Department is to alleviate the health manpower shortage in Utah and the surrounding intermountain states. We have often dealt with the problems discussed in the Congressional Record; i.e., that it is extremely difficult to recruit, support, and retain competent physicians in small rural communities. We have therefore proposed the use of physician extenders (physician's assistants or nurse practitioners) for cost-effective,

quality health care.

We are in the process of opening such a clinic in Wendover, Utah, under the auspices of the HURA project. Wendover is typical of the remote community in that no medical services are presently available except an ambulance and emergency medical technicians. They are approximately 100 miles in any direction from physician services and do not even have a pharmacy in town. The population of Wendover itself is approximately 1,000 permanent residents with another 500 residents in the surrounding area. This is not enough to support a full-time physician, even if we were able to recruit one to live in such a remote and isolated setting. At various times in the past, physicans from Elko and Salt Lake City have visited Wendover on a weekly

or monthly basis, but have soon tired of such a trip.

We will be opening a clinic in Wendover late this Spring which will be staffed by a Medex or Nurse Practitioner and an office assistant. Back-up for the physician extender will be provided through the University of Utah Family Practice Center located in Salt Lake City. In addition, the clinic will have an onsite mini-computer which will provide online quality-of-care monitoring and assistance in diagnosis and treatment of approximately 85 percent of the problems seen in primary care practice. The back-up physicians will be linked to this computer by telephone line and will receive a printed chart record of each encounter for review. The quality-of-care review will be conducted according to preset criteria established by the primary supervising physician, thereby insuring quality of care on an immediate feed-back basis during each patient encounter. The mini-computer will also do the patient billings, thirdparty payer claims, and clinic management tasks. We feel that this is a major step forward in providing high-quality rural health care without the presence of a physician on site.

One of the problems we have been unable to solve at this time is reimbursement for services delivered to Medicare and Medicaid patients by the physician extender when the physician is not onsite. Non-acute and non-emergency problems can be scheduled for the weekly visit of the physician; however, emergency and acute problems will have to be either referred to Salt Lake City, 120 miles away, or billed directly to the patient. Since HURA project monies are for service to patients in medically underserved areas, it is anachronistic that Medicare funds cannot be used to reimburse services de-

livered under a federally funded project.

The Public Health Service is extremely interested in this project as a demonstration of what could be accomplished in our area using mid-level practitioners with the computer back-up. We are planning to replicate this type of clinic at several other sites in the Intermountain West. Other communities where we would be likely to establish this kind of clinic have a greater proportion of both Medicare and Medicaid patients and provisions for reimbursement under Medicare and Medicaid would be essential to the financial survival of the clinic. The financial success of such an operation may stimulate other communities and health care delivery groups to establish similar kinds of operations throughout Utah and the Intermountain West. Certainly, an assurance of reimbursement for services provided would eliminate one of the problems now faced in similar situations.

We would recommend that reimbursement be made for the services provided by physician extenders in the same manner and at the same rate as for services

rendered by such personnel while the physician is physically present.

We would also recommend that the physician should be onsite with the physician extender at least one full day every two weeks and preferably one day each week. In addition, the physician who is serving as preceptor or

another physician taking calls should be available 24 hours each day for consultation. Prior to the beginning of service delivery, the physician should establish a written procedures manual to define the role of the physician extender in handling the problems encountered in primary care. This should include standard operating procedures for handling acute, emergency, chronic, and well-child and adult visits. In addition, for each type of visit, the method of gathering of subjective and objective data, defining the problem or diagnosis, and prescribing treatment, as well as referral procedures, should be delineated. Review of the services performed by the physician extender should be conducted by the physician on a weekly basis. Written policies for clinic management and accounting procedures should be available at this time also.

Mid-level practitioners or physician extenders eligible to be reimbursed under this proposed legislation should be certified by their appropriate professional board, i.e., the National Commission on Certification of Physician's Assistants or the American Nursing Association in addition to being licensed

in the state where the services are performed.

In conclusion, let us state our wholehearted support of Senate Bill 708. If we can be of any further assistance to you in this matter, please do not hesitate to call on us.

Sincerely yours,

DONNA M. OLSEN, Ph. D. ROBERT L. KANE, M.D.

STATEMENT OF RONALD L. HAMMERLE, D. MN.1

TESTIMONY RELATING TO THE PROPOSED "RURAL HEALTH CLINIC BILL"

I appreciate the opportunity to provide testimony relating to proposed changes in Part B, Title 18, of the Social Security Act, which would, if adopted, permit reimbursement of health and medical services rendered in rural areas by physician assistants and nurse practitioners.

For nearly three years, I directed a statewide health program in Iowa, designated to bring preventive health and medical services to families in rural areas. For the past year, I have directed a program designed to establish new health and medical services in rural areas of four midwest states—Missouri,

Kansas, Iowa and Nebraska.

Your proposed bill is definitely a step in the right direction. It makes little sense for the federal government to sponsor training programs for mid-level practitioners on the one hand, and then continue to be the last health insurance intermediary to pay for services rendered by those who you trained.

I. HOW WOULD THIS LEGISLATION ASSIST SMALL COMMUNITIES?

First, the bill will encourage physicians who now wish to hire physician assistants (PAs) and nurse practitioners (NPs) to do so with assurance that

services thereby provided will be reimbursed.

Secondly, you have correctly recognized that many physician assistants and nurse practitioners would practice in medically-undereserved rural areas if opportunities were fully available. While your bill removes one of the federal inhibitors to rural deployment of new health personnel, it does not, and can not, address the restrictive, inflationary and anticompetitive effect of state-enacted licensure laws. Until we are able to introduce real competition and efficiency incentives into the provision of health and medical care, maldistribution and skyrocketing inflation will continue. (I have included two additional speeches, with editorial highlights, to further describe the effect competition would have for provider distribution and medical cost controls. Both articles have been reprinted, in condensed form, in the Health Services Management Journal.)

Thirdly, your proposed bill should eliminate some physician fears over proper utilization of mid-level practitioners (PAs and NPs). Midwest physicians who

¹Dr. Hammerle is director of Health Resources, Ltd.; a member of the American Society of Law and Medicine; and a lecturer in bio-medical ethics at the University of Missouri Medical School at Kansas City.

have, or wish to, utilize the services of PAs and NPs have been inhibited by

the Medicare restrictions your bill seeks to eliminate.

Beyond the remedial legislation you propose, steps will need to be taken to inform the public about the qualifications and high levels of service that midlevel practitioners can provide. In many rural areas, I have found that the public initially regards PAs and NPs as "second class doctors." Once patients have had an opportunity to receive primary care from such practitioners, however, they are almost universally enthusiastic. I believe, however, that these are educational barriers we can overcome.

ever, that these are educational barriers we can overcome.

Without directly reimbursing mid-level practitioners, medical consumers, or confronting state licensure laws, your bill will not directly bring new medical services to rural areas. It will, however, provide a better federal climate for physicians who are already disposed to hire and appropriately utilize mid-level practitioners in rural areas. Such encouragement, however, will be de-

pendent on the manner of reimbursement.

II. IN WHAT MANNER SHOULD REIMBURSEMENT BE MADE?

If a physician is to assume ultimate legal and financial obligations of employing PAs and NPs, it would seem that any regulations above and beyond those now required of physician providers should not be added if you wish to encourage rural physicians to employ mid-level practitioners.

Health service providers are already so emeshed in paper processing that many physicians, particularly those in rural areas having little access to management assistance, simply refuse to participate in government programs.

To encourage utilization in rural areas, reimbursement must be simple and

easy.

One alternative would be to provide reimbursement at a fixed percentage of currently applicable fees for physician-delivered care. A formula of 75% or 80% might be considered.

The merit of this system would be that it does not create a new and expensive bureaucracy, or create new conditions for participation in the Medi-

care program.

"All primary care services and supplies" currently provided under the Medicare program could be covered, when rendered by a "physician extender."

Such a reimbursement system would be consistent with federal goals of cost control; would not require expensive or elaborate new administrative mechanisms; would not directly compete with or challenge existing rural physician providers; and if quickly and simply processed, would encourage physician participation.

You have proposed eight, reasonable requirements for reimbursement. There

are two problems with your list:

1. Judging from past history, the legislative intent of such criteria will no doubt emerge from DHEW and SRS as fifteen pages of regulations, and rural

physicians will have no part of the program.

2. Item F, requiring written policies to govern the management of the clinic, while well motivated, will similarly provoke major administrative regulations and costs, and result in frictions between DHEW administrators and rural physicians.

Again, I believe physician delegation of authority under existing regulations is the most advisable course if you seek rural physician participation in the

program.

III. WHAT REQUIREMENT SHOULD A CLINIC FULFILL IN ORDER TO QUALIFY FOR REIMBURSEMENT?

Aside from being located in a rural area, as defined in your proposed bill, I believe the Medicare program already has sufficient definitions of clinics and other provider entities. No further definitions or regulations are needed so long as you continue to rely upon state-licensed physicians to be responsible for the supervision and employment of mid-level practitioners.

IV. WHAT TYPE OF CERTIFICATION PROCESS SHOULD BE USED FOR THE PROVIDERS WHOSE SERVICES WOULD BE REIMBURSED UNDER THIS LEGISLATION?

The issue of certification and licensure is critical in developing a more costeffective, evenly-distributed, and consumer-sensitive health system.

I do not believe that certification for federal reimbursement should rest with organizations that have primary loyalties to protecting the economic and professional self interest of their members, or with organizations that have interests in restricting the number, type or scope of services rendered by persons entering the ranks of prospective health care providers.

I would redefine the certification provisions of section (3) of your proposed

bill.

My recommendation would be to certify for federal reimbursement any graduate of a "physician assistant" or "nurse practitioner" program funded by or equivalent to those programs now supported by the Department of Health, Education and Welfare.

With appropriate modifications, I believe your proposed bill can have a positive effect in encouraging the employment of mid-level practitioners in

rural areas.

[An address by Ronald L. Hammerle, I lowa Conference on Health Personnel: Recruitment and Alternatives, Des Moines, Iowa, November 15-17, 1976]

NEW MEDICAL SERVICES AND COMMUNITY NEEDS

WHAT HEALTH PROFESSIONALS AND PRACTICE ALTERNATIVES WOULD BEST MEET YOUR NEEDS?

INTRODUCTION

It is a pleasure and an honor to follow Dr. Bond Bible, whose name, and work, are synonomous with rural health concerns in many parts of the country.

I would certainly second a number of the recommendations he made this

morning, and in other major conferences on rural health care.

At the same time, I would like to share another perspective that might be helpful as you consider options for new rural health services in Iowa.

SUMMARY

I would like to suggest four options for providing and organizing health care—particularly in rural areas. In the afternoon panel session, we can become as specific as you want, with regard to how these can effect your individual communities.

1. The majority of attention should be focused on developing new, primary care services that do not require hospitalization, because this is the area of greatest need. At the same time, rural and small town hospitals can play a

major role in helping attract new medical services.

2. Group practices, or medical practices with shared services, are about the

only way to develop long term structures for primary care.

3. The introduction of professional competition in the health industry offers the best solution for controlling costs and distributing health providers.

4. Private business and consumer organizations may play a significant new role in the future of health care—despite prevalent talk of ever greater federal involvement.

I. PRIMARY CARE

The rural hospital

For better or worse, we have developed a hospital-centered medical system, despite the fact that the majority of medical needs do not require such complex, high-cost institutions. The major reason is because that's how the federal government and the Blues (Blue Cross/Blue Shield) have decided to pay benefits for illness.

Despite almost unanimous agreement that we have too many hospital beds, virtually all previous efforts at control have been unsuccessful in stopping the growth of urban hospital complexes. This is not a forum to discuss medical economics, but is it important to acknowledge the hospital as one of the chief financial and professional centers in organizing current health services.

I believe rural hospitals can play a major role in helping communities attract new physicians and other health providers. This is particularly true

of multi-hospital systems, with good management.

¹ Dr. Hammerle is Director of Health Resources and a member of the faculty of the University of Missouri Medical School at Kansas City.

In Kansas and Missouri, we are currently working with some experimental new systems in rural areas that combine better utilization of hospitals with an increased productivity for medical practices.

Physicians benefit from the management skills and shared services of the hospital, and the hospital can convert unneeded inpatient facilities to out-

patient care.

Such a system, might offer possibilities here in Iowa. Perhaps some of you can tell me later, whether such rural medical centers are already developing

In any event, the future direction is clear, even for those with major financial or professional interests in the hospital field. Outpatient, or ambulatory care, is the wave of the future.

I think this offers some exciting new frontiers for rural hospitals.

Mid-level practitioners

Beyond refocusing our attention to ambulatory care, I believe great attention should be devoted to what some call mid-level practitioners-or primary care extenders—physicians assistants and nurse practitioners.

Dr. Bible will be heading a panel this afternoon specifically on this topic, and I know that most other conference participants would welcome an "oppor-

tunity to talk about the role they see for these new health providers.

From my standpoint, I see them as the most cost-effective general practitioners our health education system can train today. Their low visibility and underutilization are the result of health-industry politics and state participation in professional restraint of trade. But we can explore that further in seminar sessions, if that is of interest to you. Here, I'd like to focus on what we can do now-in the present environment, and I think, we have substantial opportunity.

Mid-level practitioners offer a great opportunity for extending the availability of primary care services in both rural and urban areas. As a matter of fact, many trained, mid-level practitioners are now hiding within the walls of urban medical schools and hospitals because the climate for their utilization and acceptance has not enabled them to fully employ their medical skills in

the areas of greatest need.

Somehow, I think we have moved ahead backwards in our utilization of non-physician health providers. At the time when a physician's skills are most needed—in life or death situations—we have quickly trained and massively deployed paramedics (EMTs and MEMTs) throughout the country in a remarkable program of emergency medical services. At the same time, we are still inhibiting more thoroughly trained physician assistants and nurse clinicians from providing physical examinations and primary medical care! That just does not make good sense! It is an area that individual states can immediately change without expense—and without going to Washington.

I think most studies will show that mid-level practitioners are able to provide between 60% and 80% of the kind of care rendered in a general medical

Physician assistants and nurse clinicians are not the sole answer to rural health, or primary care in the cities, either. But mid-level practitioners are a real, underutilized health resource than can substantially meet the primary care needs of many Americans. This is one avenue your community can take immediately toward helping add new medical services in a rational and effective manner.

Physician placement

The third sub-area I'd like to explore is that of physician placement and

Professional placement, in virtually all fields, has remained much as it did during the age of guilds and apprenticeships. For centuries it has operated informally, and without visible structures. Thus, any change in that system

is bound to be met with some skepticism and resistance.

This is particularly true in medicine, where, until recently, physicians were recruited by small, select, and often urban-based peer groups. Once settled, they remained geographically immobile—usually until death, retirement, or changing neighborhoods moved them. The physician who relocated was viewed with a good deal of apprehension.

We find that pattern is beginning to change—some would say quite dramatically. Physicians are voluntarily becoming mobile like the rest of the population—and oddly at a time when the rest of the population is becoming less mobile!

As a result, your frontiers for physician recruitment no longer begin and end at Iowa City and Des Moines, but must truly be viewed regionally, na-

tionally, or internationally.

New efforts are being developed in some rural states to sponsor statewide career and placement days, which offer clinicians and communities the opportunity to publicly meet. We recently had such a gathering in Kansas City

Other states, notably Minnesota, have developed state-operated placement agencies. I believe Iowa is now in the process of establishing such a program.

Aside from these, the best public job market is the classified section of the Journal of the American Medical Association. From there, you can focus your sites on the specialty journals as your needs become more limited. New physician placement organizations have developed to parallel executive search organizations that have served the corporate and business community for decades. I'm not talking about your routine employment agencies. I'm talking about where major corporations go when they are looking for top executives—and where hospitals go if they don't recruit full time.

These avenues are all helpful in finding physicians.

These avenues are all helpful in finding physicians.

We have found, however, that locating physicians is only about 10% of the problem. Sixty per cent of our work lies in preliminary community and professional liaison to insure that new health providers will compliment existing medical services, and meet the differing needs of individual communities. The remaining thirty per cent of our work in rural areas involves planning the structure and first year of new medical practices, to avoid the unfortunately prevalent problem of what we call "revolving door doctors." Eighty per cent of new businesses fail in their first year. We have found a surprising rate of medical practice failures in rural areas because little attention has been paid beyond the actual recruitment of a new physician.

II. GROUP PRACTICE

Technological change in medical care can only be classified as revolutionary, despite the fact it has not produced any significant increase in American public health indexes in the last 25 years! This technological fascination, and the structure for medical provider reimbursement, has changed the organization of health care in our country.

§ House calls are a thing of the past in virtually every part of the

country-urban or rural.

§ The emergency room of the hospital has become the "after 5 medical center," or the "7-11 clinic."

§ Patients in most parts of the country no longer have a personal physician. Instead, they have a series of specialists and perform their own preliminary diagnosis before making an appointment.

Hospitals are becoming legal, and de facto regulators of the quality of

medical practice. § 95% of the current medical students at Kansas University Medical

School are considering only group practice. Medical practices are influenced by this history of organizational change. A doctor's practice is effected by these external realities-and by what he or she is taught in medical school.

As a former Iowan, who views this state as progressive, I've been impressed with Iowa's attitude that not all change is good. While Iowa may not be first with a new idea, it usually adopts the new ideas that work well and avoids the new ideas that don't pan out.

I think group practices are here to stay, and I think they represent a positive change in medical care. I can't say that of all the other external

factors previously cited, but I can say that about group practice.

For that reason, I think rural areas need to look at a group practice structure as almost essential for recruiting or retaining physicians.

By group practice, I don't mean the physicians have to form a legal marriage. Experience has shown they break up almost as fast as conventional marriages! What I do mean is some type of professional association that shares services, facilities, oncall and peer support, with time off for one's

family and other benefits.

No one has articulated this better than your own Bob Rakel, at the University of Iowa. Tomorrow morning at this time, you will have an opportunity to see and hear this in more detail directly from the U of I Department of Family Practice. Their film has become a national standard in describing rural group practice.

So . . . when you think of new physicians, think group practice.

In our work, we first try to develop this in conjunction with current physicians practicing in the area. Sometimes it works; other times you have to start from scratch. Where physician graduation dates are more than ten years apart, it's often an undesirable situation for a professional marriage.

III. PROFESSIONAL COMPETITION

Despite public images of the A.M.A. as a staunch defender of the free enterprise system, most physicians—and the health industry as a whole—are resistant and exempted from the operation of a free market economic system. This, I would argue, is part of our current problem in the cost and distribution of health services.

What we have in most of the industry, is government trained, government subsidized, government capitalized, and government protected private monopo-

lies.

To those who may have heard or read 2 a speech I delivered to the Iowa Public Health Association in Sioux City earlier this year, I apologize for reiterating this brief description of what a free market economy would have

built as a health system.

"Many existing hospitals would not have been built if they had to rely on consumers, rather than the hospital trade association (the American Hospital Association's Blue Cross plan) and the government to pay their bills on a cost plus basis. They would not wastefully compete for limited, high technology surgery or duplicate other services unless there was a legitimate consumer market.

"Physicians would be organized in wide area medical groups, work reasonable hours, utilize outpatient systems better, take advantage of company-paid continuing education, and leave the frustration of paperwork, personnel and 'government interference' to corporate management (or their union). They would utilize nurse practitioners, physician assistants, health associates and effective transportation and communication systems because they make good sense professionally, economically and in their desire to serve more patient (customers). Small towns and rural areas would not be without medical services, because competition in the cities and wide area medical practices would enable groups to profitably and comfortably serve even rural areas.

"Administrative costs would be reduced in all areas. Corporate computers and data processing units would give service providers the first chance to compete on an equal basis with third party paper processors. Large corporations would build and franchise health maintenance centers, and establish their own ambulatory care system to compete with (higher cost) hospitals

and the Blues.

"Finally, these corporate citizens would raise their own money in the marketplace for building day and night clinics, medical offices, and hospitals where the need existed. They would use the least expensive, rather than the most expensive, delivery systems and personnel. Then, they would not only pay for the city services they use, but would pay their taxes and public dividends from what some of our tax-exempt, publicly-built, expansionist hospitals now call 'operating surpluses.'

"That's the kind of health system a free market economy would build." I believe competition in the health industry offers the best solution for con-

trolling costs and providing a better distribution of health providers.

But to introduce competition in the health industry requires some action in state legislatures, and some changes in provider reimbursement formulas. The application of antitrust laws are a significant start.

² Reprinted as a two part series in *Health Services Management Journal* (Denver, Aug.-Nov. 1976): "Selling Health: a dramatic new concept regarding the delivery of health care services."

I take this meeting to focus on the here and now. What we can do today is to deal with the system as it exists, and help it better meet rural needs. Toward this end, hospitals and management organizations can develop new, cost-effective structures that we can describe more fully in this afternoon's sessions.

IV. NEW CORPORATE OPPORTUNITIES

In Missouri and Kansas, we are not only working with communities, hospitals, multi-hospital systems and our medical schools, but also attempting to encourage farm organizations and industries to consider establishing their

own medical service system.

Farmland Industries took some early initiative in bringing in mobile diagnostic units that provided screening tests in several states having farm cooperatives. While the initiative has to be heartily commended, several problems have plagued the program. Local doctors were generally not involved or enlisted prior to many of the mobile clinic visits. A number of prominent health officials are skeptical of the cost-benefit of multi-phasic screening. And finally, the program has been oriented toward only incidently relating to the development of permanent medical systems in rural areas. The year round needs are much the same after the vans leave: too few local, permanent health care structures.

Despite these observations, Farmland Industries has played a major corporate role in trying to reshape rural health services. They have sponsored conferences, and alerted their members to the kind of new health systems that will be needed in developing permanent rural health programs. I'd be happy to provide a copy of the Farmland News article: "What the doctorless town can do." It's an excellent article to share early with your local doctor

recruitment committee.

We believe that rural area cooperatives, major national retail stores, and corporations with interests in the well-being of rural America offer the greatest potential for developing the new medical systems of the future—for both rural and urban America.

They have the existing membership groups, delivery systems, administrative mechanisms, capital ability and legal capacity to employ physicians, build clinics, collectively bargain with hospitals, pharmacies and surgical specialists, negotiate with the feds-in short, to change the current picture of health care in rural America.

CONCLUSION

I can tell you that the physicians are available and interested in rural practices.

I don't need to tell you that the community need is there.

I can't speak for farm organizations or major corporations with whom we have dealt, other than to say plans are now under consideration for new corporate initiatives in the medical field.

This conference may provide you with some workable guidelines or contacts—if you can sort out the differences and conflicts you'll find among

I don't think anyone here—or on a national level—has THE answer to redeveloping medical services in rural America.

What we have found is that local initiative makes the difference between a town's medical growth and survival, or its demise as a source for local care. With a few simple guidelines, that you may find consistent in this con-

ference, it's your initiative that will make the difference.

[An address to the 49th Annual Meeting, Iowa Public Health Association, Sioux City, Iowa, May 14, 1976, by Ronald L. Hammerle]

SELLING HEALTH 1

INTRODUCTION

One of the advantages of being an "outside speaker" is that you can say what you really think, without worrying about what your boss or colleagues might think.

Reprinted as two part series, Health Services Management Journal, (Denver, Colorado), Fall 1976.

It's even nicer to be an "outside substitute speaker," because the speech title, if not the message, has already been chosen by someone else. If you succeed, you can claim the message was yours. If you're driven out of town, you can claim the message was your predecessor's. In the latter case, you can leave feeling confident that when everyone returns home, your audience has only someone else's name on the official program!

So, I can speak to you as a free agent today, and share a few ideas about

health services.

SUMMARY

I have only three points, and some examples that have led me and others to these conclusions.

First, the introduction of a free market system in the health field may offer the best, untried alternative to planning and delivering health care. Secondly, the history and future of public health advances lie more with unspectacular changes in lifestyle and simple procedures than with breakthroughs in surgery, or medical technology.

throughs in surgery or medical technology.

And thirdly, the key to the next major public health advance may come from salesmen, rather than biomedical researchers, physicians or technologists.

Ι

The introduction of a free market system in the health field may offer the

best, untried, alternative to planning and deliverying health care.

If this sounds like bicentennial whoopla or an argument for preserving the status quo, take another look at our current system. We have three major players: the commercial sector, the government sector, and the consumer sector.

THE COMMERCIAL SECTOR

The commercial sector already plays a major role in the health industry prior to the point of sale. It funds most of our medical journals, books and professional conferences. It develops and provides virtually all of the medical supplies, drugs, technology and devices used in medical practice. The commercial sector supports a majority of our medical research and development, both in its laboratories and at medical schools. It designs and constructs our offices, clinics, hospitals, instruments and equipment. The commercial sector is rapidly taking over the management, ownership and construction of hospitals, and is producing some of the few achievements in putting the breaks on skyrocketing hospital costs. It is corporate profits that establish the foundations, grants and charitable contributions that are still much sought after in an era of government medicine. Finally, it is successful business that pays the taxes which finance public sector efforts in all fields, including health.

So, selling health is not a new concept. Where the commercial sector and marketplace economy are noticeably absent are in the organization and delivery of health care at the point of consumer service—and that's where some

of the most interesting changes are now beginning to take place.

THE GOVERNMENT SECTOR

The concept of fee-for-service sounds decidedly American on its surface—as American as the A. M. A., you might say! But if you look closer, you'll see that this functions only in a very limited way as a government-protected

monopoly. It has few characteristics of a free market system.

Government protected monopolies for the training and licensure of physicians have been with us during a good part of this century. They have only been extended to the hospital field in more recent years. But the public is now being asked to enact similar restraints of trade to protect the economic territory of all sorts of other workers. While professional licensure has been sold to the government for the purpose of protecting the public, I can't think of any such licensure that has been the result of public pressure! Furthermore, if professional licensure is designed to protect the public, why does the public have so much difficulty in trying to require the professions to demonstrate continued competence?

While government licensure and regulations may have been well-motivated, they have generally resulted in soaring medical costs, limited numbers of practitioners, overtraining, poor distribution, restraint of trade, and the overbuilding of high cost facilities—the very problems that now plague the public! If you doubt these are consequences of government regulations and licensure protections, consider what would happen if a free market operated in the medical and hospital field.

Many existing hospitals would not have been built if they had to rely on consumers, rather than the hospital trade association (the American Hospital Association's Blue Cross plan) and the government to pay their bills on a cost plus basis. They would not wastefully compete for limited, high technology surgery or duplicate other services unless there was a legitimate

consumer market.

Physicians would be organized in wide area medical groups, work reasonable hours, utilize outpatient systems better, take advantage of company-paid continuing education, and leave the frustration of paperwork, personnel and "government interference" to corporate management. They would utilize nurse practitioners, physician assistants, health associates and effective transportation and communication systems because they make good sense professionally, economically, and in their desire to serve more patients. Small towns and rural areas would not be without medical services, because competition in the cities and wide area medical practices would enable groups to profitably and comfortably serve even rural areas.

Administrative costs would be reduced in all areas. Corporate computers and data processing units would give service providers the first chance to compete on an equal basis with third party paper processors. Large corporations would build and franchise health maintenance centers, and establish their own ambulatory care system to compete with hospitals and the Blues.

Finally, these corporate citizens would raise their own money in the marketplace for building day and night clinics, medical offices, and hospitals where the need existed. They would use the least expensive, rather than the most expensive, delivery systems and personnel. Then, they would not only pay for the city services they use, but would pay their taxes and public dividends from what some of our tax-exempt, publicly-built, expansionist hospitals now call "operating surpluses."

That's the kind of health system a free market economy would build. What have we built instead, with public tax dollars, monopoly licensure and government regulations? You who are most concerned with *public health* can reiterate the systemic problems of our medical system as well as I can.

If a free market health system sounds like a better approach, it can generally be established by state action. Consumers and providers could work together to facilitate such a system. State legislators, attorneys general, or administrative officers could also initiate or support such changes.

The states that would benefit most are those with the greatest medical needs. The first beneficiaries would be residents of small towns and rural areas, but in the long run, consumers, many providers, and supportive public

officials would all benefit.

The beauty of initiating this kind of chance is that you don't need to go to Washington, get a federal grant, write a lengthy proposal, hire more people, or ask the public to support another costly government study that's never read. And what could be more appropriate for our bicentennial year? It's as American as apple pie: free enterprise!

THE CONSUMER SECTOR

There's only one problem with this approach. We've lived with government-protected, professional monopolies for so long that many people don't believe that the American commercial system can really solve the organizational, supply, economic and distribution problems that government has created or supported.

The public has been treated to so much specialized training, professional elitism, and dependency on others for basic needs and services that even well-educated people have lost a belief in their own abilities to solve and manage simple problems.

Fortunately, three developments are forcing us all to look more closely at a commercial alternative in the field of health care.

1. As rich as we are, America has a finite amount of money it can spend

on health care, and we're fast approaching that limit now.

2. Some medical consumers (who are also taxpayers and voters) are just beginning to see that they may stand a better chance in a competitive market-place than in a regulation-bound system of government-protected monopolies. As it stands now, many medical consumers are paying three times for health care: once as taxpayers; once as consumers of non-competitive office medicine; and again as payers of inflated hospital insurance premiums.

3. The Federal Trade Commission, the Justice Department and the courts

3. The Federal Trade Commission, the Justice Department and the courts have finally begun to provide some relief from restraint of trade, price fixing, conflicts of interest, and other non-competitive practices in the professions. But the real battles will be decided on a state level, and that's where the

troops are organizing.

I believe we are standing on the brink of a potential, major, reorganization of the health service delivery system. The greatest reform, for both providers and consumers, could come not from national health insurance or more government regulations and funding, but from a government withdrawal to allow a free market system to begin to respond to the needs of health and medical consumers.

Having shared these conservative political and economic views on the medical system, I would like to restate and support a concept that public health officials have articulated for years, with very little public apprecia-

tion. I personally believe the public is starting to listen.

II

The history and future of public health advances lie more with unspectacular changes in lifestyle and simple procedures than with breakthroughs

in surgery or medical technology.

While few would quarrel with that as an historic statement, some are more skeptical with that as a future prediction. They seem to believe "that national health insurance, more doctors and greater use of high-cost, hospital-based technologies will improve health. Unfortunately, none of them will." Last year, our country's health expenditures rose by more than \$14 billion,

Last year, our country's health expenditures rose by more than \$14 billion, to \$118.5 billion, or 8.3% of the gross national product. Less than 3% of this went toward the prevention of disease. As a nation, we have made no significant progress in achieving international recognition under standard

public health indexes. But perhaps progress is at hand.

Having earlier scolded government officials for preserving a high-cost, non-competitive medical system, it's only fair to give praise where praise is due. It is our legislators who deserve the national health prize for the most significant advance in public for at least the last decade. Do you recall their largely unheralded accomplishment? Right, reducing the highway speed to 55 miles per hour. That accidental byproduct, to use two, double entendres, is responsible for saving 12,000 lives annually and avoiding 120,000 automobile injuries. It can truly stand as the most significant public health advance in recent years. And to what high, humanitarian, public health motivation and expensive research do we owe this advance? The operation of marketplace economics! We wanted to reduce petroleum costs and unwise energy consumption!

There ought to be a lesson there. I think it reinforces my first argument for the marketplace, as well as my second point: public health advances

come in simple and unspectacular ways.

Perhaps we will soon reach the conclusion toward which the World Health Organization is moving. In a recent publication, the WHO advocates the deprofessionalization of primary care as the most important single step in raising national health levels!⁵

Earlier this morning, I had the occasion to have breakfast with health educators. What a field day they might have when their message reaches con-

sumers through marketplace channels!

² Dr. John Knowles, president of the Rockefeller Foundation and former director of Massachusetts General Hospital, as quoted in the Wall Street Journal, March 22, 1976.

³ Health By The People (Geneva, World Health Organization, 1975), edited by Kenneth W. Newell; cited by Ivan Illich in Medical Nemesis (Random House, 1976), p. 227.

Their message of prevention and education have been the basis of good public health for years. But only recently has it been supported and amplified by consumer action ranging from women's self-help clinics, to mass interest in cardiopulmonary resuscitation, to a soon-to-be-best-selling book on the problems associated with iatrogenic diseases (caused by doctors) and consumer apathy.

The public is ready for health education, if effective approaches are used. And where do we look for effective educational approaches that work?

To the marketplace.

Television, radio, music, magazines, films, newspapers . . . and occasionally books. Advertising and mass media will sell your product or service if it has value to the consumer, if you deliver what you promise, and if you sell it in an attractive way. But you first have to talk broadly and simply enough to reach a mass audience. Health education needs to take consumers and their existing information channels as seriously as it does physicians and its current government patron.

Health educators need to sell their service, to convince consumers its worth buying, and present the case in the commercial language of the people. Is health education worth buying on the open market? I'll ask you. Would you buy your own health education services if you had to pay for them at the point of service? If not, governmental patrons ought to stop using

public monies to support an unwanted health service.

I think there's a good public market for health education and preventative health care. Where can we look for effective programs? To the marketplace.

My favorite, current example is Weight Watchers International.

As professionals with a preventative health orientation, how many medical problems can you link to obesity? Hypertension, heart attacks, strokes and kidney failure . . . A pretty good batch of public health problems, and many are amenable to treatment or prevention through weight control and altered diets.

As a knowledgable health consumer who tries to reduce contacts with the medical system, I've been a cyclical dieter for years, but with only moderate success. If Weight Watchers employees don't succeed in what they're selling, they'll go broke and be without jobs. They're not a government program so they have to try harder. They have to sell in the marketplace, reach potential customers, price their service competitively, build where there's

a market, and succeed in what they promise.

Closer to the medical establishment, I've been very impressed with how dentists have been selling preventative self-maintenance care and at the same time working on systematic application of fluoride. They know what reinforcement is . . look at all that red stuff left on your teeth! They've also led the health and medical industry in other areas: attractive public educational exhibits; consumer education in the office; early utilization of mid-level practitioners; outpatient surgery; and the administration of an-

esthetics by the prime operator.

I think the American Red Cross, with a little sex appeal and promotion, would do a better job selling its health programs in the marketplace than most colleges and universities. (On second thought, that probably understates the Red Cross' potential!) Public interest in CPR (cardiopulmonary resuscitation) courses are one of the hottest public health issues going. And what really mobilized the public after all these years? Television. More specifically, CBS' program 60 Minutes. Even the Red Cross' two volume basic and advanced first aid manuals would be good sellers. Have you seen them recently? They've got some of the most straightforward medical education available, on health concerns ranging from birth to death.

But all of this presumes a generally-motivated and receptive consumer. What do you do about those who get your message, but then don't really change their unwise health behavior? (Are there any cigarette smokers, obese

persons or alcoholics in the house?)

Here's where we bring on the salesman from good ol' American industry.

III

The key to the next major public health advance may come from salesmen, rather than biomedical researchers, physicians or technologists.

⁴ Illich's Medical Nemesis, which is already a best-seller in Europe and Latin America.

There are many consumers interested in public health. Some are highly motivated, and will change health behavior if you tell them why it is important. But there are two large groups of people that won't change behavior on the basis of education. One group doesn't have sufficient willpower

or reinforcements. The other group doesn't want to change.

People in the first group know good health behavior, but somehow they just can't act accordingly. It's like a re-run of that nightmare we've all had. Someone' chasing you. You know you want to run and try, but your feet just run in place or stick in the mud! The fact that many of us in the health service field find ourselves in this camp proves that behavioral change is not produced by education alone. (Any theologian or clergyman will confirm that.)

If you are still skeptical, silently ask yourself, as a well-educated, health professional, the following questions: Do you always drive less than 55 miles per hour? Do you fasten your seat belt and harness every time you ride in a car? Do you eat, drink or smoke too much? Do you always use effective prophylactics during intercourse to avoid venereal disease and unplanned

pregnancy? Do you floss your teeth every day?

They're all good health behaviors that we know effect personal and public health, but we probably don't always act on them. We may try to sell them to our customers, and get angry when they don't follow our advice . . . Remember that from your childhood? You catch mother doing the same thing. She gets angry and falls back on that old line: "Do as I say, Johnny, not as I do!"

What's really involved here? In sinister terms, it's called behavior modification. In common conversation, it's called motivational psychology. In religion it's called a matter of will. And in the marketplace, it's called selling.

For the group of health consumers that wants to change health behavior but lacks the motivation, you can use selling and voluntary behavioral modification techniques with few legal or ethical problems. It helps people do

what they want to do.

But there's the second group that knows the consequences of certain health behaviors, but doesn't want to change. For them, good health is not their highest value. There are other values and joys in life that are more important. In the words of an old country music song, they want to "live fast, love hard and die young, and leave a beautiful memory."

If you try to impose your health values or behavior mod techniques on them, you do so at great legal and ethical peril. But even so, we sometimes try in the name of health.

One the public health end of the spectrum, we legally require passengers on safe airplanes to fasten their seat belts, sit upright, and refrain from

moving or smoking at certain times during travel.

In the medical arena, I remember when doctors and hospitals used to righteously haul Jehovah's Witnesses into court to force them to receive blood transfusions against their will and religion! Now our courts have upheld the rights of patients to refuse medical treatment; to avoid involuntary incarceration in mental hospitals unless they present a danger to public safety; and the right to obtain certain types of medical care, notably elective abortion.

If we're right in believing that future advances in public health will come from selling better self care, then I believe we will need to look beyond health education to bring it about. Much success in the past has come from the applied psychological skills of salesmen and saleswomen, who work in the voluntary realm of a free market economy. It is to them that I believe we

might turn for assistance in successfully advancing public health.

Between the shores of "knowing" and "doing," however, lies a great river, teeming with ethical alligators, pedagogical sharks, professional crocodiles, and legal octopuses. The health professionals who succeed in helping crocodiles, consumers across that river will be the ones who can best employ marketplace tools to engineer and build a bridge. They will be the salesmen and saleswomen of real, health progress.

[Kansas City Star, Tuesday, Feb. 1, 1977]

MEDICAL SCHOOLS ARE NOT ALONE IN FIGHTING PHYSICIAN SHORTAGE

(By David Zeeck)

Legislators, medical schools, rural communities and state agencies aren't

alone in trying to solve the problem of too few doctors in the hinderlands.

For instance there's Al Tikwart, mayor of Westwood Hills and a printing executive, who thinks he may have an answer to the problem. It's called a living endowment—a system under which the medical student pays the full cost of his education (from about \$25,000 to \$46,000 a year) or works off the debt by practicing in medically underserved areas.

Or there's Ron Hammerle, director of a Kansas City firm called Health Resources Ltd., which searches for new doctors to join urban group-practices or

hospital staffs.

The hardest thing a rural community may face in trying to get a new doctor, he says, is not in actually finding that doctor.

"It's politics and planning for that doctor's first year of practice that cause 90 per cent of the problems," says Hammerle, whose firm occasionally is called upon to find a physician for a small rural town.

Hammerle explained that very often there is considerable resistance on the part of the existing medical establishment to a new doctor coming into an area.

"They feel it's a threat to their income, that it will hurt them economically," says Hammerle. "You have to spend a lot of time showing them that the extra doctor can take away some of the burdens they now carry, and that he'll help broaden the base of the medical economy in the area.

"You also have to show the established doctors in the area that the new

doctor can build a practice without taking (patients) away from them."

Hammerle noted that adding a doctor to a community or rural area means

that the doctors already there will have to spend less time, for instance, making emergency calls at hight. The addition of a new doctor ensures that the local hospital or pharmacy won't go out of business should the already established doctor die or become disabled.

It also benefits small communities when a new doctor comes to town, because people will come to that community not only to attend to their medical needs

but to shop and spend money.

"It's really a good deal for a small town to get a physician or add another," Hammerle says, "but you'd be surprised how often they're turned away or driven away by resistance from the local community."

Hammerle says his firm does another 30 percent of its work placing doctors in rural areas in assuring that a new doctor's first year (the "make or break"

year) will be a success.

Hammerle says there are several ways of overcoming the first-year problems.

Among them:

Try to form the existing doctors into a small group practice, to which you add the new doctor. Doing that, says Hammerle, spreads the costs and burdens of individual physicians among several. If that fails, convince the community to accept the new doctor as part of a small group-practice that can be built around him.

Get the new physician started through service contracts—such as serving the local hospital as its emergency-room physician, or serving as the doctor for a local business or manufacturer, or doing the on-call work of other local physicians. Each of these arrangements has the advantage that much of the work is paid for by a third-party insurer, costing the existing doctor nothing and relieving some of their burdens. Contract work also provides the doctor with a chance to meet potential patients who don't already have a family doctor.

Tikwart's approach is more direct.

For several years he's been gathering information and speaking to whoever will listen (from governors to national political parties to friends) about a plan he says will solve much of the problem in short order.

Here's the rationale and the plan:

"In Kansas, where I live, the medical student is paying \$1,500 a year tuition," Tikwart says. "The taxpayer is getting little or nothing from that, be-

cause about 66 per cent of the graduates leave the state.

"What I propose is that we have the student pay the full cost of his education (which, Tikwart estimates, costs from \$26,000 to \$46,000 a year) or \$20,000 a year, whichever is less. Or he can get forgiveness on that debt by serving in a medically underserved area.

"The greater the area's need, the quicker the graduate's debt is forgiven.

And he keeps all the income."

A plan similar to Tikwart's is being drafted by Rep. Mike Hayden (R-Atwood), and is to be introduced in the Kansas House this week. Hayden's plan is modeled after a similar one in Colorado, which has been in operation four years for dental students. None of the dental students in Colorado has decided to pay the full cost of his education, moving more of them into areas lacking in dental services.

Tikwart will this week seek to have Kansas Jaycees, meeting in convention,

adopt the plan.

"The plan helps everybody," Tikwart says. "It keeps the medical students we educate here in the state. It helps the rural citizen who's paying taxes that subsidize medical education, but getting little out of it. It answers the need of the legislators who need an answer to the problem. And it helps the medical schools by giving them a solution to the problem before the legislature or the federal government comes up with a solution for them."

GRAND VIEW COLLEGE,
OFFICE OF THE DIVISION OF NURSING
AND ALLIED HEALTH PROFESSIONALS,
Des Moines, Iowa, March 18, 1977.

Mr. David Harf, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR SENATOR: Thank you for sending to us the documents relative to the Rural Health Clinic Bill, S708. I wish to submit the following statements germane

to that bill:

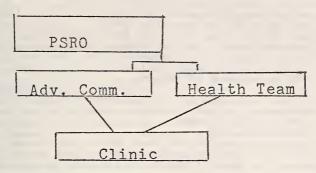
1. The legislation as proposed in 8708 would assist small communities to receive health care as professional nurses could establish clinics to monitor and refer patients as needed to physicians in larger centers. Cost containment would be effected through disease prevention by health promotion strategies. These professional nurses could help identify disease entities which the client did not perceive existed. Further, illnesses can be prevented by utilization of health teaching. Each patient would accrue a health history and record to validate effectiveness of health teaching and screening. Preventative programs in weight control, hypertension screening, etc., could help reduce these two big problems in rural and urban communities. Venereal disease programs could be taken to the grass roots by people who know people, which is a powerful and effective group. Further, we believe that the bill should include rural areas, but should not be limited to communities with less than 50,000 population. What about underserved areas in cities where physicians are not interested in establishing a practice for many of the same reasons as indicated for the rural area?

2. Reimbursements should be made.—Payment should go directly to the person providing professional service(s). A specified consultation fee would be paid for each client, for the physician supervising the clinic. Each medicaid-medicare payment would indicate amounts for consultation and for identified professional

services.

3. Requirements that a clinic should fulfill—Clinics should have an Advisory Committee composed of a physician, nurse, and/or physician's assistant, community leaders, citizens from different age strata and socio-economic strata, professionals and non-professionals (8-10 members). This committee should determine clinic hours, physical plant site and maintenance thereof, and general operating policies (fees and services). Further, the health team (supervising physician and nurse) will determine the areas of services for the clinic and the parameters for referral along with standing orders for those conditions which can be treated at the clinic site. Policies relative to record keeping, based on modified

Weed's (problem oriented records) should be established by the Health Team. Quality of care can be evaluated from the records by the problems and the care proposed and the evaluation of the outcome on individually randomly selected records. The Health Team would report to the *PSRO* and the Advisory Committee of the clinic. If the clinic did not meet PSRO review, it would lose reimbursement for services.



4. Certification-Professional nurses, with at least baccalaureate in Nursing degree, and who have had physical assessment, health education, modified Weed's Record keeping principles, as well as theory and practice in nursing in the episodic and distributive settings, with great emphasis on maintaining and promoting health, as well as helping to restore those who are ill, and currently registered in the state they reside in, should meet the minimum certification process as providers whose services would be reimbursed under Bill 8708. Physician assistants are orientated to the medical model and their focus is on diagnosis and treatment of illness. Nurses who are prepared as Family Nurse Practitioner (FNP) who are prepared at the Master's level, would be ideally prepared in functioning at the level as indicated in your Bill. However, the number of nurses prepared at this level is limited. Our one Master's program in this state graduates a limited number of nurses prepared in other specialty areas, but none as FNP. You refer in your bill to "nurse practitioner as certified by the American Nurse Association"-I do not believe that that should be the only identified nursing group. This is a very limited group of specialized nurses who meet that criteria. We believe that nurses prepared at the baccalaureate level and with family nurse practitioner courses, or clinical specialists prepared at the Master's level, will be able to make such assessments and referrals.

Attached, is the objectives of the clinic and for the baccalaureate students for a clinic we proposed to establish in the Harding Community in Des Moines.*

Sincerely,

JUANITA R. THEILE, Chairperson.

STATEMENT OF CHESTER W. DOUGLAS, D.D.S., PH. D., ASSOCIATE PROFESSOR, UNIVERSITY OF NORTH CAROLINA

I am pleased to have the opportunity to present testimony to the Subcommittee on Rural Development regarding Senate Bill 708 on rural primary care health clinics. I will limit my remarks to a consideration of the preventive and environmental health services that must be made available in these centers. Rural health centers must be especially enabled to deliver a broad range of family oriented preventive services to residents in rural America. Without such services, traditional medical care services are not effective and long lasting.

Two levels of preventive services should be considered: first, individual preventive services such as immunizations and fluoride treatments; and, second, family and household oriented preventive services such as nutritional services,

^{*}Retained in files.

and home water, heating housing services. A third set of community services dealing with communicable diseases, community water supplies, and air pollution should be delivered by community health boards and departments in close coordination with rural primary care centers. Without the financial support from national health services funding sources such as Medicare, the severely limited resources in rural primary care centers do not allow for the delivery of these essential primary prevention services.

As a general strategy, it is recommended that services at all three levels

As a general strategy, it is recommended that services at all three levels should be initiated as primary preventive activities or in response to a presenting clinical problem within the primary care center. Examples of presenting conditions would include: pregnancy, diabetes, obesity, heart disease, tooth-ache, trauma, black lung, poisoning, and arthritis. From these and other clinical conditions specific individual. family and household and community preventive

services should be designated for delivery.

It is critical to health status impact that preventive and household environmental services be recognized as essential component of primary health care. Primary health care centers need to include a provider who has the job and is accountable for providing preventive and household environmental services within the primary care center.

The following recommendations for the inclusion of environmental and preventive services in rural primary health care centers were made in the Report of the Southern Rural Health Conference in Nashville, Tennessee on October

10-12, 1976.

1. Protocols and standing orders should be written that will provide standards of care for all these categories of preventive and environmental services.

2. Alternative models of integrating preventive and environmental health services should be studied and compared in terms of thier relative effectiveness.

3. The primary care center should work to strengthen community health

service support systems within the community; e.g., Build strong direct referral mechanisms and, Recognize and utilize existing structures of rural social

organizations such as churches and agriculture groups.

In order to enable the delivery of these services this legislation should be amended to permit and encourage preventive services. Specifically, I would strongly encourage that S. 708 explicitly incorporate language that would permit Medicare and Medicaid funds to include categorical reimbursement procedures which would pay for individual preventive services, health education, and household level family oriented preventive services.

If you or your staff would desire additional information on these comments

I would be most willing to provide further clarifying information.

Thank you.

[Western Union Mailgram]

College of Osteopathic Medicine and Surgery, Des Moines, Iowa, March 23, 1977.

Senator Dick Clark, U.S. Senate, Washington, D.C.

Dear Senator Clark: I am in receipt of a copy of rural health bill \$.708 sent to me by your office requesting review and comment.

I hope that you will recall that I was in attendance during one of the hearings

in Iowa.

I am in total agreement with your stance that the development of a rural health system is mandated if we are to meet one of the major problems of our society. I feel that medical care is a right rather than a privilege. However, unless nurse practitioners and/or physician extenders are closely supervised by physicians, while patients may receive relatively good care for illnesses which are self-limiting and which would normally vanish in the course of time, or there may be effective screening for conditions such as hypertension or diabetes, we may be creating a dangerous situation by providing less than adequate care for the elderly citizens who constitute a high risk population in many illnesses. Another real concern is that we may create a situation in which para-professional personnel will flock into small communities in which many elderly people live because of the inducements of a lucrative practice largely paid for by direct medicare reimbursement.

As you know, the college of osteopathic medicine and surgery conducts 10 low income clinics, several of which are rural. Despite the fact that our primary health providers are senior medical students, who in a matter of several months will be physicians, no student is permitted to deliver care unless a physician supervises them closely. These students are obviously much better equipped to

deliver such care than physician assistants.

I understand your concern, on the other hand, I believe that in attempting to correct a very important defect in the health care system for the elderly, this bill may create a situation in which license will be given to less than qualified people to be reimbursed by the social security medical care section and may, therefore, attract a disproportionate number of para-medical providers to small communities because of economic inducements to become medical entrepreneurs. In so doing, a temporary amelioration of the problem will be effected. However, it may also discourage a trend beginning to build among new medical graduates to serve in other than urban areas in our state.

Yet another concern is that there is at least one inequity built into this bill; namely, we are allowing such providers to be eligible for direct medicare reimbursement because they will practice in rural areas. I am sure you are aware that the same problem exists in many urban ghettos, particularly in the parts of the city in which other than Caucasians maintain residences. Consequently, if the bill is important to alleviate the health problem of the elderly in rural areas, it may be of even greater importance to have such a bill allowing for reimbursement from para-professional persons in urban ghettos where such diseases as hypertension are having a devastating effect upon the black population and tuberculosis and diabetes on Chicano population. If the physician's assistant can give care to the non-urban citizens why not allow him to practice in the city? What will then result to quality control in medical practice?

I regret I can not give a more glowing or optimistic report of what is certainly a well intended, but unfortunately potentially problematic, solution to the lack of health providers for rural Iowa and/or rural communities in the Nation.

I was present and heard the representations of the good people who were pleased with their physician extender. Personally, I was gratified that they had had such a happy experience. On the other hand, the whole concept of the physician extender or nurse practitioner is so new that one can not assure the quality of all of the programs and/or the graduates therefrom, particularly in the early years. I hope you will give this matter deepfelt consideration and perhaps invite some persons who have had an extensive experience in this area, such as representatives of this college which had served both urban and rural Iowa for many years, to visit with you and examine in detail the concept developed in the bill and perhaps reshape some of your thoughts.

Again, I congratulate you for your concern, you have demonstrated both compassion and a desire to do something about a present problem. I must also extend a note of caution that action may sometimes come too early and create greater problems than continued restraint, if at the same time a process for developing a

better solution is ongoing.

With warmest regards, I am cordially yours,

J. LEONARD AZNEER, Ph. D. President.

March 24, 1977.

Hon. DICK CLARK, U.S. Senate,

404 Russell Office Bldg., Washington, D.C.

DEAR SENATOR CLARK: Thank you for allowing me to comment on S.708 pertaining to Medicare reimbursement of Physician Extenders.

It has become more evident that rural health physicians have found a need to utilize Physician Extenders. This has increased his efficiency and quality of care in general. I feel that Physician's Assistants can help their physicians immensely in continuing this pattern. Medicare reimbursement for services performed by a Physician Extender would greatly add to that. In my opinion, 80% reimbursement to the physician who employs the P.A. would be equitable.

I would define a Physician Extender as an individual who has been certified by the National Commission on Certification of Physician's Assistants to the primary care physician. This certifying examination is open to Physician Extenders and is of highest quality. The Physician Extender must also be under the responsible supervision of a physician. To allow the use of a "collaborative" physician instead of a "supervising" physician could greatly jeopardize the concept of the Physician Extender. This, in itself, opens the door to an independent practitioner without supervision.

Most of my colleagues in Nebraska are in rural areas of less than 5,000

Most of my colleagues in Nebraska are in rural areas of less than 5,000 population. They wish to remain and continue in giving quality care to all people of all ages. This amendment would greatly aid in giving rural Nebraska

the quality of care they justly deserve.

Thank you for allowing me to express my opinion on this issue, and also for your concern in this very important matter.

Sincerely,

LESTER D. HAKE, Physician Assistant.

Drs. Zimmer & Colon, P.C., University Nebraska Medical Center, Friend, Nebr., March 29, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

Dear Mr. Harf: I have been asked by Governor Exon of Nebraska to respond to your request for written testimonial regarding Medicare reimbursement for the Rural Health Clinical Services. It is my opinion that it is self defeating for HEW to continue to disallow compensation for services performed by a physicians assistants and nurse practitioners not under the direction of the physician. Under the current guidelines a physician has to be present during the care rendered by those extenders so in fact he might as well perform the services himself. This destroys the effectiveness of these aids in providing medical services for larger numbers of people in rural areas.

By saying that I do not believe that direct supervision is necessary I do not mean to imply that the physician extenders should not be supervised at all. Daily consultations with the responsible physician concerning any question of policy, therapy, or referral must be a part of the program. The unsupervised extender becomes an illegal practitioner of medicine on the one hand with serious questions of legal liability involved and on the other hand he may become a tool of unscrupulous entrepreneurous. Even in areas where physicians are not readily available the medical practice acts those states would have to be changed considerably to allow extenders to practice unsupervised. A physician is ultimately responsible for the care given a patient it has been my experience that physicians assistants do not desire to take on the total responsibility of patient care. Permanent satellite clinics with little direct contact with the physician are open doors to abuse. Thus I recommend that physicians extenders services be reimbursed by Medicare as long as there is some form supervision of the services performed.

Sincerely,

V. F. Colon, M.D., Associate Professor of Family.

STATEMENT OF GORDON CASE, TRI-COUNTY FAMILY MEDICINE, DANSVILLE, N.Y.

As the administrator of this nonprofit community corporation, I feel that Medicare reimbursement for services provided by a Registered Physician Assistant is essential to the provision of quality care for the millions of Americans living in rural areas.

Tri-County has employed one PA for over three years and has recently hired a second to assist our group of four family physicians. Our PA's work in the outlying towns of our service area and while they have a physician in the building a majority of their time at the center, they are the only provider for significant portions of the week and while MD's are on vacation. Because of the present Medicare reimbursement limitations, the aged and disabled must often choose between paying for care without Medicare assistance or traveling

further to a doctor, or waiting longer until the MD returns to the office. Legislation such as S. 708 will extend to Medicare patients the same access and free choice available to other citizens.

For over three years we have used the same fee schedule for MD's and PA's.

I feel there are four compelling reasons for this approach;

1. Due to physician developed PA guidelines and review of PA charts, patients receive the same high quality care for the more limited range of problems treated by the PA.

2. PA care requires an unseen component of MD time in review and discus-

sion which must be reimbursed.

3. PA's typically spend more time with the patient for the same given prob-

4. The decision on who sees the MD rather than the PA must be a medical

decision rather than a financial one.

It would seem that providers eligible for reimbursement must be certified by the appropriate state licensing or registration function. In New York State this presently would mean Physician Assistants qualified for registration by the State Education Department based on their education. In New York there is no licensed category of nurse practitioner or clinician as distinct from the R.N.

Tri-County supports the development of the Physician Assistant concept and believes that S. 708 is a vital step in this development. However, the PA does require extensive physician participation to develop full potential, and frequent opportunity to work with the supervising physician is a necessity. The PA cannot fully develop into a fully functioning provider with only telephone communication and referral backup. An active MD component is essential to long term PA success.

[Western Union Mailgram]

ITHACA, N.Y., March 27, 1977.

RICHARD CLARK, Senate Office Bldg., Washington, D.C.

SENATOR CLARK: Urge revision of S. 708, rural clinics reimbursement as follows: Replace "physician supervision" with "position consultation which is reimburseable."

Rural New York nurses are independently presently providing health care with physician consultation and have proved their expertise in assessing when physician involvement is needed. The physician supervision clause of 2–708 is regressive and prohibits expansion to numerous unserved areas.

District 7, encompassing 3,000 nurses, urges prompt passage of S-708 with the

above revision.

Sincerely

JOANNE BYRNES, President.

STATEMENT OF SHARON MONLEY, R.N., BOISE, SIDNEY C. PRATT, M.D., GREAT FALLS, JOHN W. GEEDES, PH. D., BOISE, MOUNTAIN STATES HEALTH CORPORATION, BOISE, IDAHO

Dear Senators Clark, Church and Metcalf, Thank you for the invitation to submit testimony in support of S. 708 at the hearing on March 29, 1977.

For the past seven years the Mountain States Health Corporation, a non-profit organization devoted to improving the quality of health care in the rural mountain West, has been responsible for introducing family nurse practitioners into Idaho, Montana, Nevada and Wyoming. We have recruited capable nurses from rural communities and used HEW funds to secure their education as nurse practitioners at established universities (Colarado, Utah, Stanford, North Dakota, Montana State, Arkansas). To assure success of these new health workers, we have helped residents and physicians in rural communities to accept this new health provider. Most of them have remained in their home community where their rancher and logger husbands make their living. They are serving in the underserved, rural hamlets that no longer attract and hold

a physician. They are accepted providers of primary health care and should

be paid for services they render to Medicare patients.

We are presently introducing nurse practitioners to serve another medically underserved rural population. Through a grant from the W. K. Kellogg Foundation, our staff has been recruiting nurses to be educated as geriatric nurse practitioners (GNPs). They will work on the staffs of thirty skilled nursing facilities in the mountain West. Upon completion of one year of special education and meeting state licensing or certifying requirements, these geriatric nurse practitioners care for Medicare and Medicaid patients in skilled nursing facilities. These are patients who, like those identified in S. 708, for the most part, are in rural, underserved areas. Their needs for primary health services are not adequately met by present physician visits at 30-60-90-day intervals. These geriatric nurse practitioners work in concert with a physician. Their records are maintained and regularly reviewed by a physician. The SNFs have established admission relationships with hospitals. The GNP represents a major new hope for quality improvement in nursing homes—especially those in rural areas.

With emphasis on rehabilitation and preventive care, patients and staff will strive for maximum patient independence. Earlier discharges based on sound planning and GNP follow-up can be expected to increase. It is anticipated that many skilled nursing facilities with a GNP on the staff will begin to offer ambulatory health maintenance services to the elderly. This service will reduce the need for costly inpatient services and offer personal independence for many Medicare patients.

Ten GNP students will have completed their didactic education at the University of Colorado in May of this year. They will return to places like Moscow (pop. 14,146) and Twin Falls, Idaho (pop. 21,914) and Bigfork (pop. 600), Livingston (pop. 6,883) and Bozeman, Montana (pop. 18,670). Others are ap-

plying for education in the coming year.

The facilities in which they will work are the leaders in the nursing home field, committed to improving the quality of their services. They should be reimbursed by Medicare funds for services they render.

It is in this connection that we wish to propose the following modifications

in S. 708.

GENERAL

1. In addition to the reference to "rural health clinic services" we urge inclusion of "rural skilled nursing facilities."

SPECIFIC

2. New Subsection (aa) (1) be amended as follows, adding the underlined

words, deleting those marked by (XXX):

"(aa) (1) The term "rural health clinic or skilled nursing facility services means such services and supplies as would otherwise be covered (under subsection (s) (2) (A)) if furnished as an incident to a physician's professional service, or such additional services provided by a physician extender, furnished by a rural health clinic or skilled nursing facility to an individual as a primary care patient." "(2) The term 'rural health clinic' or skilled nursing facility means a facility which—(A) is primarily engaged in providing rural health clinic services or skilled nursing facility services; . . ."

Speaking only to the manner of reimbursement for services that have been provided by family or geriatric nurse practitioners, we suggest that it be based either on a fee for service or as a salary that is reimbursed to the facility as a part of its usual costs in a reimbursement claim. These two alternates

should be available.

In all cases the nurse practitioner should have an established, written working relationship with a physician who serves as a knowledge resource and a colleague backup for the nurse practitioner. He must agree to accept referrals and be available for consultation and assistance. Part of his obligation is to regularly (at least monthly) review the records and work of the nurse practitioner. The nurse practitioner and the physician may be geographically separated, but they must be able to communicate by reliable telephone, radio or interactive television. These conditions should be met to qualify for reimbursement. They are workable in the mountain West.

Each nurse practitioner should have completed a formal training program at an established institution of higher learning. The program should be at least

one year, at a minimum, in length including a minimum of three months of didactic experience plus a preceptorship or supervised experience of at least eight months. Until such time as a national standard or license is established, the nurse practitioner should be licensed as an R.N. and certified as a nurse practitioner within the state in which practice is planned, meeting applicable state license requirements.

So much of a continuing effort to improve the quality of care in rural SNFs rests upon the education and introduction of GNPs to those facilities. A substantial part of the success of this quality improvement effort depends upon recognition by Medicare reimbursement. We strongtly urge your favorable con-

sideration of S. 708 and the suggested revisions in this testimony.

Thank you for this opportunity to comment.

NATIONAL ASSOCIATION OF COUNTIES, Washington, D.C., March 31, 1977.

Hon. Dick Clark, 404 Russell Senate Office Bldg., Washington, D.C.

Dear Mr. Chairman: The National Association of Counties (NACO)¹ strongly supports enactment of S. 708 amending Title XVIII of the Social Security Act to allow reimbursement for primary health services performed by physician

extenders.

The 1967-77 American County Platform, the official NACo policy document, endorses the expanded role of nurses and other health professionals in providing health care as well as efforts to secure a more equitable distribution of health manpower. Permitting reimbursements for physician extender services (whether or not the supervising physician is physically present) and reimbursement rates based on the type of service rather than the classification of provider are consistent with NACo's policy objectives. Furthermore, licensed professional nurses should be reimbursed for the performance of functions within the scope of state licensure even when not under the direct supervision of a physician.

The use of physician extenders is especially critical to areas where a physician scarcity exisits. The Secretary of Health, Education and Welfare (HEW) has designated over 6500 geographic areas, including over 1,500 counties, as medically underserved areas. The remaining 5000 areas represent census tracts or portions of counties. In addition, 238 counties have been identified by HEW's Bureau of Community Health Services as areas of "greatest need" (areas where services are not presently being provided through their health projects.)

HEW estimates that 45 million people reside in these medically underserved areas. Nineteen million reside in urban areas, and 26 million in rural areas, where access to care is further impeded by inadequate transportation and other geographic and economic factors. The acknowledged shortage of services to rural counties is a function of the maldistribution of health manpower and resources rather than total numbers. The trend of medical specialization, the prospect of professional and social isolation, lower income, and heavier work loads have been factors discouraging physicians from establishing rural practices. For many physicians, a medical practice requires locating near a large university medical center. Consequently, rural people must travel further to obtain health care than their urban counterparts.

In addition, many rural counties have inadequate resources to provide emergency medical care to their residents. The rural population, which is generally older and poorer than the nation as a whole experiences higher rates of chronic and work related illnesses than urban residents. Migrant farm workers share the rural resident's lack of access to health services. This is further compli-

cated by their mobile life style.

¹The National Association of Counties is the only national organization representing county government in the United States. Its membership spans the spectrum of urban suburban, and rural counties which have joined together for the common purpose of strengthening county government to meet the needs of all Americans. By virtue of a county's membership, all its elected and appointed officials become participants in an organization dedicated to the following goals: improving county government: serving as the national spokesman for county government; acting as a liaison between the nation's counties and other levels of government; and achieving public understanding of the role of counties in the federal system.

To try to alleviate the maldistribution of health services, Congress recently passed a major health manpower act increasing the number of scholarships and insured loans to students in health professions agreeing to practice in underserved areas. Programs under the Public Health Service—the Rural Health Service—the Rural Health Initiative and the National Health Service Corps—also seek to encourage the development of a rural health system. Other innovations have been initiated by the Robert Wood Johnson Foundation and the Appalachian Regional Commission. NACo has also been working, via its Rural Health Project, to assist underserved counties in establishing urgently needed primary care services.

All of these innovations rely in one form or another on the combination of physician extenders for "first line" care with physician supervisor and back-up for more complicated diagnosis and treatment; providing the basis of an orga-

nized system of primary care.

The benefits of uring physician extenders have been demonstrated in terms of the quality and cost of patient care. Numerous studies confirm that clinics providing physician extenders services reduce the number of days their rural patients spend in hospitals. Physician extenders are trained to place a high priority on prevention and primary care resulting in significant reduction in the need for costly hospitalization.

NACo concurs with the determination that the most appropriate and feasible mechanism of payment of physician extender services is direct reimbursement

to the free standing clinic.

In the past, physician services and services "incident to" a physician (i.e. physician extender services) have been based on "reasonable and customary" charges, leading to a serious problem of reimbursement differentials between urban and rural areas. The lower rural reimbursement rates based on "custom" have created a major disincentive to the establishment and maintenance of physician and physician extender practices in underserved areas. We therefore endorse the section of the bill stipulating reimbursement rates based on reasonable costs, which would help alleviate the disadvantage to rural areas under past medicare reimbursement policy.

Medicare restrictions against payment for physician extenders services have created a bias against rural counties and inner cities in need of health care and impeded the recruitment of both physician extenders and physicians to underserved areas. The federal government has actually played a conflicting role in the physician extenders issue—by funding physician extender training programs and encouraging the use of these "mid-level practitioners" in underserved areas, while refusing to allow Title XVIII payments for their services.

The bill (S. 708) currently being considered is crucial to efforts to correct the inadequate access to primary care services existing in many parts of the country. NACo advocates the extension of physician extenders reimbursement to urban as well as rural clinics. The resulting change in medicare Part B policy would lead the way for recognition of physician extender services and their payment by Title XIX programs and other third party payors. The change would also be a major step towards holding down the skyrocketing rise in health care costs.

Simply, Mr. Chairman, reimbursement for services rendered should be based on the procedure and not the professional status of the provider; fees should

be scheduled to the least expensive appropriate provider.

In summary, we maintain that the use of physician extenders should make medical care more accessible and less costly. If you have any questions about our position, please contact Mike Gemmell of our national staff.

Sincerely,

TERRENCE PITTS, Chairman.

CENTRAL PENNSYLVANIA HEALTH SYSTEMS AGENCY, INC., Lewisburg, Pa., March 28, 1977.

Senator DICK CLARK, 404 Russell Bldg., Washington, D.C.

DEAR SENATOR: As staff to the Central Pennsylvania Health Systems Agency, Inc.'s Primary Care/Emergency Health Service Committee, I wish to support S. 708 which would have a beneficial impact upon our rural region.

With the support of the Appalachian Regional Commission, ten communities have developed community-based primary health centers during the past seven

years. Other communities have used other means to develop primary care facilities, and group practices have begun to organize. Since these were situated in the less remote trade areas of the region, physicians were successfully recruited. Some centers, however, required physician extenders to supplement the care given by the physicians. While these efforts have improved the delivery of care to most of our region's residents (75% of the people are now within a 30-minute drive of primary care services), some problems still exist.

The problems are two-fold: (1) inadequate delivery of primary care to the remote portions of Central Pennsylvania and (2) inadequate reimbursement

for primary care services in general.

(I) In Central Pennsylvania, those areas still in need of primary care services are not sufficiently populated to support a primary health center with more than one physician. Since recruitment and retention of physicians to practice on a solo basis in remote rural areas is improbable if not impossible, any effort to bring primary care to such areas must depend upon the physician extender as the principal primary care provider. Such efforts, however, would be futile if extenders were not reimbursed for services to Medicare patients, for in Central Pennsylvania, as in much of rural American, the percentage of elderly people is increasing while that of younger people is decreasing (see Table 1, attached). In addition, the two areas most in need of services, the remote and the urban, have higher percentages of elderly people than do the semi-rural and suburban (see Table 2, attached). Any method of primary care delivery, then, for those areas still in need would require reimbursement

for services rendered by physician extenders.

(2) Because of the previously critical shortage of primary care manpower, existing physicians could afford to restrict their patient load to those who could afford to pay out-of-pocket or to those whose health insurance provided adequate reimbursement. Once primary health care centers are operating they become the sole provider of service for many Medicare patients who have previously been unable to find care. This situation places a double burden upon the primary care center when physician extenders are employed. The result is that the community or individual patients must then subsidize the Medicare and Medicaid patients care through fund-raising efforts or increased fees. Complicating the problem is the fact that median incomes in rural areas are lower than in urban areas, and that primary care services are not covered under most health insurance plans. The final result can then be that a center cannot sustain itself financially and must close. Then we are back to the problem of inadequate delivery of primary care.

In support of S. 708, I emphasize not only the need to reimburse under Medicare for services provided by physician extenders, but also to provide adequate Medicare reimbursement to all primary care providers. One without the other is just window dressing: to appear to be meeting rural needs with-

out the real effort required.

Sincerely,

CONSTANCE A. St. HILAIRE, Planning Analyst.

Enclosures.

TABLE 1.-DEMOGRAPHIC PROFILE OF HSA AREA V ELDERLY POPULATION

County	1980 elderly population	1980 elderly population projection	Percent change in elderly population	Percent change in total population	Percent elderly with income below poverty level (1970 census)	Percent of elderly population (1980 projections)
Centre	6, 439 9, 229 3, 998 6, 423 6, 082 1, 822 13, 117 4, 625 2, 422 13, 021 2, 763 2, 776 72, 617	7, 757 11, 651 5, 110 9, 303 8, 270 2, 393 15, 444 6, 291 2, 816 18, 554 3, 173 3, 414 94, 176	+20 +26 +31 +45 +36 +31 +18 +36 +16 +42 +15 +335 +30	+15 -2.4 +9 +9 0 +4 +4 +7 0 +2 +10 +3 +5.3	11. 6 24. 9 27. 0 31. 8 33. 5 24. 3 31. 9 24. 4 27. 3 32. 5 27. 3 24. 1	6. 2 16. 0 12. 4 15. 4 18. 8 13. 7 13. 3 13. 0 17. 1 18. 4 10. 0

TABLE 2.—PERCENTAGE OF ELDERLY (65 YEARS AND OVER) DISTRIBUTION BY DENSITY OF AREA, BY COUNTIES

PENNSYLVANIA

County	Remote—<50 per square mile	Rural—<1,000 per square mile	Semirural—>1,000 mi ²
Centre	8.3	7.0	10.0
Clearfield	12.8	12.1	12.8
Clinton	13. 4	7.7	10.3
Columbia	12. 2	9.9	13.9
Jefferson	14. 2	13. 2	14.7
Juniata	8.6	10.3	13.6
Lycoming	11.4	8.6	12, 3
Mifflin		9.1	12.5
Montour		10.4	14.6
Northumberland		10.0	15.1
Snyder	9. 4	8.8	11.0
Union	12. 2	8. 1	11. 3
Average	11.4	9.6	12.7

DEPARTMENT OF CONSUMER AFFAIRS, BOARD OF MEDICAL QUALITY ASSURANCE, Sacramento, Calif., March 28, 1977.

DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. HARF: On behalf of the California State Board of Medical Quality Assurance, I am writing to strongly endorse the passage of S. 708 (the Rural

Health Clinic Bill).

Our State licensing board has been very active in carrying out its responsibilities to establish appropriate training and standards of practice for nurse practitioners and physician's assistants in California. We are continually reviewing their activities and the rules governing their practice in order to increase their efficient, effective and accessible practice. While we have labored very hard to establish these categories in a responsible functioning manner, we remain very frustrated in that their impact is greatly minimized by lagging reimbursement mechanisms.

We thus strongly support S. 708 and its purposes and would only add that there are many urban clinics that could benefit from a similar piece of legislation, for there are many urban areas where the effective availability of physician services is very low and physician extenders are sorely needed. Under such circumstances, physician and hospital backup should be much

easier.

Sincerely,

Joseph P. Cosentino, M.D., Acting Executive Director.

STATEMENT OF THE RIO GRANDE FEDERATION OF HEALTH CENTERS, INC., SAN ANTONIO, TEX.

The RGFHC, Inc. is a 14-member group of Health Centers which provide care to the medically underserved and indigent populations. These centers are located in urban and rural areas throughout Southwest Texas and New Mexico. The population served totals approximately 500,000.

The centers are federally funded by various grants which include Rural Health Initiatives, Community Health Centers monies, and Migrant Health Center fundings. Each center has an active consumer board which oversees the administration of the individual centers. The policy being: to have community-based people who have an active interest in the delivery of health care.

These areas rate below the national average on physician to patient population ratio which is not conducive to providing quality medical care. In addition, it is very difficult to attract physicians to these rural sites. This is, in part, due to financial constraints but also due to the lack of interest on the part of physicians and the difficulties physicians encounter in isolated areas.

Due to the aforementioned situation, and the crucial need to have medical manpower to provide health care, physician extender providers are being

utilized. Numerous articles have been written which validate the centers' feelings that physician extenders provide high quality care, are cost effective, and increase the efficiency of health care delivery. Their utilization offers alternative pathways to health care that would not otherwise be available to the medically underserved and ignored populations.

It is the position of the RGFHC that Medicare reimbursement for physician extenders would be a positive step in improving accessibility to health care.

Physician extenders should receive full reimbursement for the services that

they provide, with the following requirements:

That there be a named supervising physician licensed to practice medicine

in the state.

That the physician be located within 25-50 miles of the physician extender. That the physician not necessarily be physically present in order for the physician extender to bill for Medicare payments.

That there be established written protocols written by the named supervising physician regarding referrals and treatment plans.

That there be a written contractual agreement between the physician and physician extender or clinic and physician extender defining liability.

That the physician extender obtain professional liability insurance.

That each physician's assistants be certified by the National Commission for Certification of Physician Assistants. And, all nurse practitioners be required to take a certification exam pertinent to their field of expertise.

That there be mandatory recertification every five years for physician

extenders.

That in the five years prior to recertification there be required continuing medical education.

That PSRO be extended in a relevant manner to physician extender activ-

ities using separate guidelines.

That there be no more than a 2-1 ratio of physician extenders to physicians to avoid "medicaid mill" problems.

That all monies received go directly to the clinics.

That each chart be reviewed and signed by the named supervising physician on a predetermined time basis.

That medicare reimbursement also include the underserved medical popula-

tion not just rural areas.

In closing, it appears obvious that lacking available and committed physician extenders will offer an effective pathway for increasing accessibility to to the medically underserved people. Full Medicare-reimbursement for physician extenders will offer an effective pathway for increasing accessibility to health care.

> COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN, Detroit, Mich., March 29, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. HARF: Based on our assessment of the health manpower situation during the development of our Health Systems Plan (HSP), greater use of the "physician extender" would seem warranted. In fact, perhaps the most promising alternative to training primary physicians is the use of such auxil-

iary health personnel.

While rural areas suffer shortages of trained personnel, our studies also indicate that central cities note a shortage of primary health care physicians. Therefore, legislation of the sort you describe in your letter of March 7, 1977, may correctly benefit both areas of our country. There are, despite apparent geographical difference of the rural and urban centers, a similarity of need in certain facets of manpower distribution. Thought might be given therefore, to how we extend such services to the central city as well.

Please contact us should you require additional information.

Sincerely,

TERENCE E. CARROLL. Executive Director. ALLEGHENY COUNTY INSTITUTION DISTRICT. March 25, 1977.

Senator DICK CLARK, Committee on Agriculture and Forestry, Washington, D.C.

DEAR SENATOR CLARK: As Chairperson, Primary Care Nurse Practitioner Organization, Western Pennsylvania I received your letter of March 7, 1977 informing us of the hearing to be held March 29, 1977 on Medicare reimbursement of rural health clinic services. Basically, we support the American Nurse's Association position as presented to you by Ann Zimmerman, R.N., President, American Nurses Association on February 28. 1977.

Specifically we support:

1. The nurse practitioner be identified separately from the physician assistant since her/his educational background/preparation is different, legal status as a registered nurse is recognized and her/his professional nursing practice is independent.

2. Revision of the terminology "supervision by a physician" to collaboration and referral since the nurse practitioner can practice independently if her actions are nursing actions as identified by the State Nurse Practice Act.

We question the section that excludes "physician directed clinic under direct personal physician supervision" since many clinics would fit this description in the rural areas. This exclusion only serves to further delete physician manpower in these areas and indeed acts as a deterrent in recruiting physicians to these areas.

We vigorously urge you to consider as well as rural clinics in this medicare reimbursement. Many of the underserved populations within the cities are

served by nurse practitioners but few full time physicians.

A reimbursement system should provide for nursing services that are directly accessible to clients and such nursing services could charge a fee for service. The cost for this type of service currently is inflated since it requires physician input and salary for some activities that are legally recognized as nursing practice but are non-chargeable unless submitted with a physician signature. This "double" cost of physician and nurse increases the end cost to the client.

Lastly, the American Nurses Association has developed a competency examination for family nurse practitioners that was offered the first time in November 1976. This examination could be the certification process needed to recognize providers whose services would be reimbursed under this legislation. This certification, if adopted nationally, would be a certification process honored nationally and would then provide mobile credentials to the nurse practitioners.

Thank you for the opportunity to share our thoughts with you.

Sincerely.

SUSAN SHEEDY, Chairperson.

THE AMERICAN GROUP PRACTICE ASSOCIATION. March 25, 1977.

Hon. DICK CLARK. U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: Reference is made to your letter of March 7, 1977, in which you announced the beginning of hearings on S. 708. The American Group Practice Association is vitally interested in this legislation and currently studying it's implications. Regretfully, this review and official position will not be available until after the beginning of your hearings. However, when that position is clarified it will be transmitted to you.

More than one-third of AGPA's member group practices serve rural populations. Many have successfully demonstrated the capability of group practice to alleviate the health services distribution problem through outreach satellite operations and innovative utilization of allied health personnel. Some of these groups also staff outreach satellites with closely supervised and directed physician extender personnel. One such group is the Morehead Clinic in Morehead, Kentucky. I am attaching a copy of testimony given by Dr. Richard Carpenter of that group to Mr. Rostenkowski's committee.

¹ Retained in files.

Not all rural based group practice physicians would agree with Dr. Carpenter's approach. For a different view, I am attaching a statement by Dr. Hugh Collett of the Elko Clinic in Nevada.

Group practices who currently employ physician extender personnel in such situation as well as groups generally would voice concern that this legislation

include:

Adequate safeguards to insure that only high quality services are provided

Strict criteria be employed in the establishment of rural health clinics to maximize chances of economic viability without continuing direct tax support Physician Extender roles be clearly defined and performance be scrupulously supervised by employing or supervising physician

Supervising or employing physician be held accountable for the functions

and acts of such personnel

Reimbursement be made to the employing physician or organization and not to the extender personnel themselves

That such personnel not be licensed but credentialed as to their training

and experience.

With respect to quality assurance, The American Group Practice Association provided the leadership in developing a quality assurance accreditation program for ambulatory care organizations. The Association operated this program for group practices from 1968 until 1975, when it was succeeded by the Accreditation Council of Ambulatory Health Care under the aegis of the Joint Commission on Accreditation of Hospitals (JCAH). We still support and participate in this activity. Although this accreditation program has not defined specific criteria for utilization of extender personnel, we believe that the high standards established for the evaluation of ambulatory care generally should apply to the rural clinics defined in your proposed legislation.

The American Group Practice Association has been working closely with

The American Group Practice Association has been working closely with the National Health Service Corps (NHSC) for the past two years in an effort to stabilize practices in rural areas. The approach here has been to establish supportive linkage relationships between NHSC sites and group practices. In many of these situations, groups have initiated the action to establish the Corps sites, and in other situations have assumed the management responsi-

bility for such sites.

Finally, the Association is clearly on record as supporting innovation to improve the accessibility of health services to the American people and are most anxious to work with the Congress and HEW to achieve these goals.

Sincerely yours.

Lon G. McKinnon,
Director, Membership Affairs.

SOUTH DAKOTA DEPARTMENT OF HEALTH,
OFFICE OF THE SECRETARY,
March 24, 1977.

DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. HARF: This is in regard to Federal legislation for the provision of Medicare reimbursement for Physician Assistants and/or Nurse Practitioners (S.B. 708 and H.B. 2504). The South Dakota State Department of Health strongly supports such reimbursement as one mechanism which should

be used to improve health care delivery in the state.

It is important to note the relationship of this legislation to our current national, state and local health policies and priorities. Congressional reports following review of the health care delivery system as described within Public Law 93-641 (National Health Planning and Resources Development Act, 1974) state that "The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government". This priority was established in recognition of national findings that there was "(A) lack of uniformly effective methods of delivery health care; (B) maldistribution of health care facilities and manpower; and (C) increasing cost of health care". In response to these findings, priorities and legislation, a major effort is now being made in South Dakota and other states to organize and implement health planning and resource development programs to improve access to quality health care at reasonable cost. I can assure you that the South Dakota State

Department of Health is concerned about the serious health care delivery problems in our State and is now taking aggressive action through the Office of Health Planning and Development to achieve these priorities.

Since the proposal to reimburse Physician Assistants and Nurse Practitioners does have considerable potential impact upon our three major priorities, additional details are provided by priority area as follows:

1. ACCESS TO HEALTH CARE

The lack of physician manpower is a constraint in obtainment of health care in the entire state with smaller communities having severe problems in this area. South Dakota has approximately one physician per 1,200 people which is two times the national average of 1 physician per 600 people. Sixteen of the sixty-seven counties do not have a physician licensed in South Dakota. Considerable additional data are available to substantiate the obvious need to

improve access.

Recognizing that there are several reasons why more physicians are not available to serve within the traditional delivery concepts and that some of these reasons are so basic that certain communities could and possibly should not try to have a fulltime resident physician, alternate methods for provision of health care services have been applied. Action was taken by the Legislature to provide for licensure of Physician Assistants (copy of SDCL 36-4A attached). In addition, the Nurse Practice Act was revised and criteria developed for certification of Nurse Practitioners by the South Dakota Board of Nurses (copy attached). As of January 1977, thirty-six Physician Assistants were licensed and nine Nurse Practitioners were certified in South Dakota. Access to health care has been improved by these personnel. In many instances, it is observed that the Physician Assistant or the Nurse Practitioner are the only access to health care within the particular town they serve. The provision of reimbursement as proposed would undoubtedly have a positive impact on total numbers and increased utilization of these personnel.

2. QUALITY

Quality of health care must be fostered and protected and there is no doubt that this can be accomplished under present arrangements pertaining to licensure and certification of Physician Assistants and Nurse Practitioners in South Dakota. The present detailed provisions for training, licensure and certification, utilization and supervision of these personnel as they are vigorously applied in conjunction with the critical evaluation of the patient should be more than sufficient controls of quality. The potential for release of the physician so that he could spend more time when necessary with the patients who require a higher capability should also be recognized.

3. REASONABLE COSTS

Some of the possible cost reduction mechanism inherent with Physician Assistants and Nurse Practitioners are less apparent than others. The increased availability of health care personnel within a community would tend to improve early diagnosis and treatment particularly in the relatively isolated rural communities where individuals may postpone needed health care due to the inconvenience of travel and long waiting periods to see the physician. This delay often results in more serious and costly health conditions. Reluctance to release patients after hospital care to return to areas without care also increases costs. Travel for the patient and the family is another increased cost which is difficult to measure but is obvious in the underserved rural area. It would be expected that savings from factors such as these would be more significant than any possible reduction which may be experienced from any potential rate reduction associated with utilization of Physician Assistants and Nurse Practitioners.

In summary, the increased usage of Physician Assistants and Nurse Practitioners in South Dakota would have a positive impact upon the national health care priorities of improved access, quality and cost. Further, Medicare reimbursement as provided in S.B. 708 and H.B. 2504 would greatly enhance

the increased prevalence and utilization of these personnel. State and local government and the health care industry have made significant advancements in health care delivery to areas of critical need by passage and implementation of legislation providing for Physician Assistants and Nurse Practitioners. We now request the Federal government to participate with us in meeting our national health care priorities by providing for reimbursement for health care delivered by these personnel.

Sincerely,

JUDITH K. CALL, Secretary of Health.

TOTAL ACTION AGAINST POVERTY IN ROANOKE VALLEY, Roanoke, Va., March 15, 1977.

Re Medicare Reimbursement of Rural Health Clinic Services.

Mr. DAVID HARF, Office of Senator Dick Clark,

Washington, D.C.

DEAR MR. HARF: We would like to submit the following testimony:

TAP is a community action agency serving the Fifth Planning District. One of the primary goals of our organization is supporting the improvement of medical care delivery to low-income citizens-many of whom live in rural areas and many of whom are over 65 and dependent on Medicare for their

health care needs.

The Fifth Planning District of Virginia is made up of four counties and four cities. According to 1970 census, three of these counties, (Botetourt, Alleghany and Craig) are considered 100% rural while Roanoke County is 36.9% rural. In each of 100% rural counties the population per primary care physician is over 3,000 persons to each doctor; infant mortality rates vary between a low of 20.5 to 38.5. Black infant mortality rates are as high as 153.8. The U.S. average for that percentage of persons over 65 receiving oldage assistance is 67.7, but those percentages in our area go from a low of 75% in Craig County to a high of 90%. 75% in Craig County to a high of 90%. S. 708 would be a step toward solving some of these problems. We would

like to make these further suggestions:

(1) Designate rural health centers as participating providers under Medicare and Medicaid with a separate reimbursement policy based on average expenditures of Medicaid recipients and Medicare enrollees in the state.

(2) Revise the Medicaid program to include low-income two-parent families regardless of welfare or employment status. Require all states to cover rural

health center services and the medically needy.

(3) Comprehensive health centers currently funded by the U.S. Department of Health, Education, and Welfare should be maintained. The Medicare and Medicaid programs should be amended to permit comprehensive health centers to receive capitation payments from these programs based upon average expenditure levels for all persons covered by Medicare and Medicaid in the state.

(4) The National Health Service Corps and Public Health Service should broaden experimentation with a greater variety of approaches to rural health including more emphasis on nurse practitioner clinics, group practices, greater role for community residents in the management of practices, and better tech-

nical assistance.

Specific additional health legislation which would help insure that rural residents receive a fair share of benefits include:

(1) Establishment of fee schedules for physicians that reward rather than

penalize physicians for practicing in underserved areas.

(2) Creation of health resources development boards with sufficient funds targeted on personnel who desire to locate in rural communities and on the development of innovative approaches to health care delivery in rural areas.

(3) Development of supplemental programs to overcome specific barriers to improved health in rural areas. Ameliorative programs would include transportation services, outreach services, and patient education services.

Very truly yours,

THE RAND CORP., Santa Monica, Calif., March 21, 1977.

Hon. DICK CLARK,

U.S. Senate, Committee on Agriculture and Forestry, Senate Rural Development Subcommittee, Washington, D.C.

Dear Senator Clark: Thank you for your solicitation of comments on the issue of physician extenders in rural health clinics. I have just returned from a three-week trip and unfortunately do not have the time to prepare written testimony by March 25. However, I believe the subject you are raising is of importance in urban as well as rural areas. Physician assistanst working as independent providers have the potential for reducing cost, improving access, and increasing competition in the medical care delivery system. The extent of this potential and the mechanism by which such providers could be reimbursed deserves careful consideration. Although I realize that the Committee on Agriculture and Forestry does not have jurisdiction over the more general problem, I believe that you could perform a service by calling attention to this matter.

Sincerely,

JOSEPH P. NEWHOUSE.

STATEMENT OF NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

This statement is submitted on behalf of the National Council of Community Mental Health Centers (NCCMHC) representing 343 community mental health centers, most of which receive federal grants under the CMHC Act, and another 176 agencies which are developing CMHC programs or which have a direct interest in community mental health.

NCCMHC supports the concepts of amending Medicare so as to include coverage for the important services provided by rural health clinics, and allowing such clinics to provide services in the most appropriate manner

utilizing the skills of physician-extenders.

This is a long overdue initiative which would begin to coordinate the various different federal health programs, which too frequently work at cross-purposes. However, the problems which face the rural health clinics and which are addressed in S 708 are similar to those facing over 600 federally-funded CMHC programs. Like the rural health clinics these rural and urban programs must rely on third party payments to survive, particularly once their federal eight-year grants terminate, and must utilize the services of all mental health professionals to provide high quality care at reasonable cost.

CMHCs are now facing conflicting requirements in federal statutes. The CMHC Act requires all centers to obtain maximum third party reimbursements including specifically Medicare funding, but CMHCs are not able to participate to any great extent under Medicare partly because they do not qualify as providers and partly because of the restrictive definition of physician supervision which is excluding many CMHC services from coverage.

THE ROLE OF CMHC'S IN HEALTH DELIVERY SYSTEM

Community mental health centers were devised primarily to bring comprehensive mental health services into the community—to provide a more appropriate alternative to state mental institutions for those unable to meet the costs of care.

However, rural and urban community mental health centers, along with other federally initiated programs such as rural health clinics, have the capacity to make substantial changes in the system for delivering health services.

Community mental health centers, for instance, represent a complete system of care for the mentally ill in the community. Each CMHC serves a specifically defined geographic area, termed catchment area, and provides a full range of services to all residents in that area including preventive services, early intervention and emergency services, an appropriate range of outpatient and other ambulatory care programs, partial hospitalization (day care and night care), half way houses where appropriate, and 24-hour inpatient services. In addition, each federally-funded center is required under

recently enacted legislation to provide a comprehensive program for mental health of children and of the elderly, two groups which have traditionally been underserved by the centers as well as by other mental health programs. In rural areas, in particular, the CMHC is often the only available service for treatment of emotionally disturbed persons.

CMHCs emphasize outpatient services, with 78.3 per cent of patient care episodes being provided on an outpatient basis, compared to 15.3 per cent inpatient care and 6.4 per cent partial hospitalization. In other mental health facilities, inpatient services, as a percentage of all patient care episodes, represent a much greater proportion of services (40%). Even for those patients hospitalized in CMHCs, stays are kept to a minimum (on average 17 days). This enables CMHC patients to remain in their community, often as productive members of society, while receiving treatment.

CMHCs are also required by law to ensure that all services are coordi-

nated with the provision of other mental health, health and social services in the community. This requirement means that in planning CMHC services, agencies are required to review all existing services in the area, to pull these together to the maximum feasible extent into a coordinated program, to make provision for filling gaps in services in the catchment area and to attempt to eliminate unnecessary duplication. CMCHs have developed extensive outreach programs to ensure that all individuals in the catchment area who have need of services are both aware of their availability and encouraged to seek assistance.

The centers preventive programs, consultation and education, include a wide range of indirect services which also help to establish an effective system of mental health care. Through C&E, the centers reach into the schools, health agencies, law and corrections agencies, welfare departments and so on to educate personnel in these agencies about the services of the center and on mental health issues in general so that appropriate individuals

are referred to the center for care.

Thus a community mental health center, as defined in federal law, is designed to make substantial impact on some of the most difficult and pervasive problems in health delivery, such as: Accessibility-both in terms of geography and socio-economic factors, emphasis on preventive care and health education. emphasis on ambulatory care and other innovative alternatives to expensive 24-hour a day inpatient services where these services are not in the best interests of the patient, utilization of all mental health professionals and para-professionals in mental health teams, and elimination of costly duplication of services to the extent this is feasible.

Much discussion in the health planning field now focuses on these very issues. For instance, the Forward Plan for Health developed by HEW last year included as major themes such issues as preventive care and health education; ways to discourage inappropriate hospital stays and to keep all hospital stays short; and accessibility, and coordination of services to improve continuity of care and eliminate duplication. The Forward Plan then suggested that CMHCs and other PHS clinics be given provided status under

Medicare.

FINANCING OF CMHC PROGRAMS

Yet while CMHCs are now, and have been for years, working towards the goals which are being given high priority by various federal health planners, they are still faced with enormous financial problems. Centers at this time are caught in a squeeze play at the federal level. On the one hand, federal categorical grants are being phased out because centers are expected to become self-supporting through collections of various third party payments, fees, and state and local funding, and on the other hand federal third

party payments are frequently unavailable.

The federal CMHC legislation provided funding on a time limited basis, now eight years, except for those centers which can demonstrate exceptional financial distress in which case eleven years of support is available. Moreover, this funding is never 100% of costs. Funding begins for nonpoverty area centers at 80%, for poverty centers at 90% of costs, and is then reduced substantially year by year to an eventual level of 25% and 30%. Clearly, then this federal seed money must be supplemented with all available alternative funds if the programs are to become viable.

Indeed the federal legislation recognizes this. Section 206(c) (1) requires

a CMHC applying for a federal grant, to assure HEW that it:

"will develop a plan for adequate financial support to be available, and will use its best efforts to insure that adequate financial support will be available to it from Federal sources (other than this part) and non-federal sources... so that the center will be able to continue to provide comprehensive mental health services when financial assistance provided under this part is reduced or terminated as the case may be"

"has made or will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other program or

private health insurance program"

Similar requirements are placed on the centers for collecting appropriate

fees, based upon ability to pay.

Hence the centers are obligated to obtain maximum feasible amounts through programs such as Medicare, and indeed if they are to survive once their federal grants terminate, they must be able to receive reimbursement for individuals covered by these programs.

MEDICARE AND CMHC'S

Federally-funded CMHCs are now unable to qualify as providers under either Part A or Part B of Title XVIII unless they are directly operated by a provider hospital, in which case the CMHC program comes under the auspices of the hospital and bills through the same provider number. However, currently only about 15% of federally-funded centers are operated by a hospital, while 62% have agreements with a provider hospital for the hospital to provide inpatient care to CMHC patients. The problem is most acute, however, for outpatient services—which is the primary service CMHCs provide. Provider status under Part B is now denied to about 85% of the CMHCs, which can thus only collect for extremely limited reimbursement through physician fees for service.

A further restriction is the definition of physician supervision which makes it impossible for many of the CMHC services to be reimbursed. At the present time there are insufficient psychiatrists to supervise all community mental health care, even if that were desirable. But in fact, it is not necessary, practical or desirable to require that a psychiatrist or physician be present when all care is provided. Not only is this unworkable because of psychiatrist shortages, but it is unwise since much of the psychological treatment required by CMHC patients can be provided by other members of the CMHC professional treatment team at less cost, and frequently more effectively.

Within an organized setting, such as a CMHC, controls on the appropriateness of care and the quality of service rendered can be made by setting conditions for operation of the provider agency, including peer and other reviews. Thus, the provider agency can be held accountable for ensuring that services are appropriate and of high quality and that patient's rights are protected. Lines of responsibility and accountability in such CMHC providers should be clear. Once such controls on quality care are in place, it is not necessary or desirable to include in the federal statute conditions regarding the day-to-day operation of the programs, especially the appropriate roles of members of their professional staff.

SPECIAL PROBLEMS IN RURAL AREAS

As of January 1976, 262 operating CMHCs were providing services to 965 predominantly rural counties and bringing CMHC services within the reach of a total population of 17.3 million. This represents 43% of the total number of federally funded centers. Nationwide, 40% of all CMHC catchment areas (including areas with a CMHC and those which do not yet have a program) serve rural areas.

Providing services in rural areas presents special problems to the CMHCs. In rural areas outreach programs are especially important in order to enable the scattered population to be within a reasonable traveling time of a CMHC

facility. It is simply not possible for the center to place a full-time physician in each of these satellite facilities; indeed many rural centers have problems recruiting physicians to work full-time in the center at all, and as a result utilize part-time physicians who also have private practices. Thus, the requirement for direct supervision of all services under Medicare is particularly burdensome for the rural centers and is excluding almost all of them from participation in the program.

Rural centers also have higher costs than do urban or suburban centers

Rural centers also have higher costs than do urban or suburban centers because of the large areas they must serve. Staff time is taken up with travel to remote parts of the catchment area, and long-distance phone calls

become a large part of the budget.

For rural centers, home visits are a most important part of services, since many patients cannot travel to the CMHC's main facility, or even in many

instances to a satellite.

Thus, the problems of delivering mental health care in rural areas is similar to the problems of providing other health services: physicians cannot staff all satellite programs, costs of services are greatly increased because of the distances involved.

S 708 would provide relief to clinics providing other health services, but does not include coverage for mental health programs serving these same

populations.

NCCMHC PROPOSED AMENDMENTS

NCCMHC supports a complete revision in the mental health benefits under Title XVIII, but is also aware that such a review and revision cannot be considered at this time. Therefore, in order to address the most pressing needs—provider status, coverage of outpatient services, and quality controls through restraints on the provider agency instead of on which professional may deliver care—NCCMHC would like to suggest a package of amendments to Title XVIII (outlined in detail in the attached document) which would: Amend Part A to include coverage of CMHC outpatient services with limits set on the number of visits per annum (NCCMHC suggests 60), require periodic and repeated reviews of services to ensure that treatment is appropriate, provide reimbursement for services provided on an outpatient basis by a qualified clinical staff member, including various outpatient therapies, day treatment and home visits, and include in the definition of CMHCs only those agencies meeting both Medicare requirements and the requirements in the CMHC Act.

Since the great majority of mentally ill persons do not need long term institutional care, nor long term outpatient services, this proposal is designed to ensure that Medicare beneficiaries could utilize community mental health center outpatient services, with appropriate limits on care per annum and with regular reviews of services. It would also ensure that inpatient services be reduced to a minimum. A limitation on the number of visits has been set in order to conform this coverage to that under Part B, and also because of the difficulty of defining spell of illness with respect to outpatient mental

health services for the elderly.

Under current law, payment for mental health services may be made only if a physician certifies and recertifies that such services are required and that treatment can or could reasonably be expected to improve the conditions for which such treatment is necessary. Under the NCCMHC proposal, these same quality controls would also apply to outpatient CMHC services.

The proposal defines outpatient services in a CMHC to include active diagnostic and therapeutic services provided in the CMHC in the patient's home

or (in a CMHC or CMHC-affiliated) day treatment program.

The term outpatient services should be interpreted broadly, so as not to restrict the setting in which these services can be provided. Currently Medicare includes under the term outpatient both traditional outpatient visits and day treatment services. However, it is equally appropriate on occasion for the therapist to visit the patient as for the patient to come to the center. Indeed both the elderly and disabled frequently require home visits because of the difficulties they experience in traveling to the CMHC facility. In rural areas, particularly, home visits are needed to reach patients who have no means of traveling the long distances to reach the CMHC facility.

Many patients discharged from long-term care facilities will require more support than the traditional outpatient visit, and for these patients in particular day treatment programs are essential. However, day treatment requires that active therapeutic care be provided more or less continuously throughout the day-day care services such as custodial or socialization programs should not be covered under this definition.

The NCCMHC proposal provides coverage for services of all qualified CMHC clinical staff members when certified as necessary and provided through a qualified CMHC with appropriate reviews. CMHCs qualified under this proposal and licensed in their state should then be free to establish appropriate

roles and responsibilities for each staff member.

Under the NCCMHC proposal the definition of a qualified CMHC is deliberately restrictive because of the absence of any appropriate nationally recognized standard for CMHCs other than the federal grant program. The major purpose of the NCCMHC proposal is to open up to Medicare beneficiaries the services of qualified CMHCs and to ensure coordination of the federal CMHC program and Medicare. Thus only centers meeting the federal definition would be eligible for reimbursement.

Attached is a more detailed summary of the changes to Title XVIII which NCCMHC is suggesting for consideration by the subcommittee. The need for action on this, or a similar plan is urgent, as about 100 centers are already operating without categorical assistance (many of them with great difficulty and only after reducing services). Without Medicare coverage, it will be extremely difficult for many of these centers to continue to provide services

to the elderly.

NCCMHC urges the subcommittee to revise S 708 so as to address the problems in Title XVIII which are excluding both rural and urban CMHCs from full participation under Medicare.

NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS, FEBRUARY 1977, PROPOSAL FOR COVERAGE OF COMMUNITY MENTAL HEALTH CENTERS UNDER MEDICARE

SCOPE OF BENEFITS

1. Amend Section 1814(a)(2) to add a new paragraph F as follows: "in "outpatient mental health services in a CMHC, for up to 60 visits per year, subject to periodic utilization review committee certification as to the necessity and appropriateness of services, as defined in Section 1814(j)."

2. Amend section 1812(b) so as to insert a new paragraph (4), as follows: "outpatient mental health services furnished in a CMHC after such services

have been furnished for a total of 60 visits per year."

3. Amend section 1812(e) to insert "outpatient mental health services in a community mental health center."

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

1. Amend section 1813(a)(2) to add a new paragraph F as follows: "in the case of outpatient mental health services in a community mental health center, such services are or were required for the mental health treatment of an individual, and such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary."

2. Amend section 1814 Payment for Services, to add a new paragraph (j) as follows: "payments for services on behalf of an individual in excess of 10 visits shall be made only after a utilization review committee of a community mental health center has certified prior to the 11th visit and prior to the 36th visit that such services are necessary and appropriate."

OUTPATIENT SERVICES IN A COMMUNITY MENTAL HEALTH CENTER

Amend section 1861 to include a definition of outpatient CMHC services as follows: "Outpatient services in a community mental health center means actively diagnostic and therapeutic mental health services furnished to an outpatient by a community mental health center, including: physicians services, phychological services, psychiatric nursing and psychiatric social work services, services furnished incident to the services of licensed mental health professionals and which are ordinarily furnished by the community mental health center (or by others under arrangements) to its outpatients, outpatient physical therapy services, and such drugs and biologicals as are ordinarily furnished to outpatients by the community mental health center.

When provided under the case management of a physician and in accordance with a treatment plan and provided through a direct service contact,

through a day treatment program or a home visit.

Such services shall not include: Inpatient services provided 24 hours a day, including bed and board and related medical, nursing and supportive services, appliances and equipment, socialization services, custodial care and maintenance, night care, public education, consultation services, other than case consultation, vocational counseling and training, services provided in a half-way house and other supervised living arrangements, except for active diagnostic and therapeutic services, special education, recreation and leisure time activities, and homemaker services.'

COMMUNITY MENTAL HEALTH CENTER

Amend section 1861 to include a definition of a CMHC as follows:

The term "community mental health center" means a public or private

entity which:

(1) is primarily engaged in providing services for the diagnosis and treatment of emotionally disturbed and mentally ill persons, has a requirement that all mental health care will be case-managed by a physician, and has appropriate arrangements to ensure that all patients requiring medical services are referred to a physician;

(2) meets the definition of a community mental health center in Section 201 of the Community Health Centers Act and the requirements prescribed

by regulation;

(3) in the case of a center in any State in which State or applicable local law provides for the licensing of community mental health centers, is licensed pursuant to such law;

(4) has by-laws in effect with respect to its staff;

(5) meets such staffing requirements as the Secretary finds necessary in order to carry out an active program of diagnosis, treatment and rehabilitation for individuals who are furnished services;

(6) maintains clinical records including such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment

provided to individuals entitled to benefits under Title XVIII;

(7) has in effect a utilization review plan pursuant to Section 1861(kk). (8) has in effect an agreement with a hospital pursuant to Section 1861(11).

UTILIZATION REVIEW

Amend section 1861 to include new section (kk) as follows:

(kk) A utilization review plan of a community mental health center shall be considered sufficient if it is applicable to services furnished by the center to individuals entitled to insurance benefits under this title and if it provides-

(1) for the review, on a sample or other basis, of admissions to the centers, and the professional services furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the center, or (B) a group outside the center which is established in a manner

as may be approved by the Secretary.

AGREEMENTS FOR TRANSFER BETWEEN COMMUNITY MENTAL HEALTH CENTERS, AND HOSPITALS

Amend section 1861 to include new subsection (II) as follows:

(II) A hospital and a community mental health center shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that(1) transfer of patients will be effected between the hospital and the community mental health center whenever such transfer is medically appropriate

as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any community mental health center which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under Section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under Section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuming extended care services for persons in the community who are eligible for payments with respect to such services under this title.

MISCELLANEOUS

1. Sec. 1861(u)—Provider of Services—add "community mental health center."
2. Sec. 1861(w)—Arrangement for Certain Services—add "community mental health center."

3. Sec. 1866(e)—Agreements with Providers of Services—add "community mental health center."

STATEMENT OF WILLIS B. GOLDBECK, DIRECTOR, WASHINGTON BUSINESS GROUP ON HEALTH

The 144 member companies of the Washington Business Group on Health provide the health care benefits for approximately 25,000,000 employees, retirees and dependents. (A membership list is attached). Scattered across the nation, these people reside in hundreds of rural communities as well as the metropolitan centers.

It is a pleasure to express our support for S.708 with its objectives of improving rural health clinic services by improving the equity of the Medicare

reimbursement regulations.

Employers are acutely aware of the dual problems of needed improvement in health care delivery and essential constraints upon the seemingly endless rise of health care costs. We feel 8.708 is uniquely designed to serve both objectives.

Further, major employers have historically used nurses as a primary and outstandingly successful professional force for health delivery in the industrial

setting.

The use of Medicare reimbursement as an incentive for, rather than against, the most cost-effective way of delivering appropriate health care services is

commendable and long overdue.

While we agree totally with the great need for encouraging the use of physician extenders to close the gaps in access to care in rural areas, we would suggest that many urban settings would also benefit from the same reimbursement adjustments.

Senators' Clark and Leahy, and their co-sponsors, are to be complimented for taking the initiative represented by S.708 and I hope you will call upon

us if there is any way our Group can be of assistance.

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The American Public Health Association is a professional society representing 50,000 health professionals, including 51 state and local affiliated organizations. The Association strongly supports S. 708, a bill to permit Medicare reimbursement to rural health clinics for primary health services.

This Association is vitally concerned with the lack of adequate health care

available to citizens in rural America.

In many areas of the country where the size of the population makes it financially unable to support the services of a full-time physician, one solution has been the establishment of clinics staffed by qualified nurse practitioners and physician assistants working under an arrangement where a physician is available for referral and consultation. The utilization of these health professionals enables more persons in rural areas to receive appropriate high quality health care. The current situation which prohibits Medicare from reimbursing for nurse practitioner and physician assistant services discriminates against rural areas, and in many cases creates a severe financial strain on rural health clinies.

This Association is in agreement with the method of financing proposed in S. 708. We really should experiment with various payment methods to support organized rural health clinic services, and should avoid payments to individual practitioners on a fee-for-service basis. Payment on a basis related to cost

removes some of the incentive to provide excessive care.

The eight requirements which are placed on a clinic before it would qualify for Medicare reimbursement should be adequate to insure high quality health care. Additionally, we support the provisions which require that nurse practitioners be certified by the American Nursing Association, and that physician assistants be certified by the National Commission on Certification of Physician's Assistants. We are confident that the criteria used by these groups will insure a supply of well trained health professionals to staff rural health clinics.

The American Public Health Association urges passage of this very necessary measure, and hopes that it will receive prompt and favorable considera-

tion by Congress.

STATEMENT OF THE AMERICAN DIETETIC ASSOCIATION

This testimony is presented relative to the provisions of S. 708, a bill to permit Medicare reimbursement to rural health clinics for primary health services.

The American Dietetic Association is a professional organization comprised of 31,700 members with approximately 65 per cent of the working membership

employed in hospitals or other health care facilities.

The objectives of the American Dietetic Association as stated in its Constitution are: "To improve the nutrition of human beings; to advance the science of dietetics and nutrition; and to improve education in these and allied areas."

At the White House Conference on Food, Nutrition and Health in 1969, dietitians and public health nutritionists were identified as the only health professionals whose education and training have been directed toward the appli-

cation of food and nutritional science to the health care of people.

We urge that the Report language accompanying S. 708 make it clear that registered dietitians are covered by the definition of physician extender. Registered dietitians now provide nutritional care and counseling on the referral of physicians in hospitals, outpatient clinics and physicians' offices. We believe that such services should be available in rural health clinics.

As a "specialist educated for a profession responsible for the nutritional care of individuals and groups", the registered dietitian (R.D.) not only has completed the basic academic and experience requirements and passed the qualifying examination for registration, but is also expected to update her

knowledge with continuing educational activities.

In the statement concerning the "Rural Health Clinic Bill" published on February 10, 1977, in the Congressional Record, there is the following: "The clinics where the extenders work have several benefits. First, the extenders tend to emphasize preventive health care. They educate patients about proper nutrition and other self-help techniques, in order to prevent the necessity for care by a physician or hospital personnel".

We commend the sponsors of S. 708 for recognizing nutritional care as a vital component of preventive health care. The American Dietetic Association believes that to promote optimal nutritional health for the population of this country, nutrition services under the supervision of qualified nutrition personnel should be a component of all health and health related programs.

In the most recent "Forward Plan for Health FY 1978-82", published by the Department of Health, Education and Welfare, nutrition is identified as the third priority of the six "Substantive priorities of the Public Health

Service".

Section 1501 of Public Law 93–641, the National Health Planning and Resources Development Act of 1974 calls for national guidelines for health planning. The "Draft Initial Statement—National Health Policy Planning Guidelines" dated October 1976, has a Statement of Goals and Subgoals that includes: "2. Health promotion should be extended through both individual and community actions. A. The knowledge and capabilities of persons to choose and develop a style of living and to adopt daily practices that maximize wellbeing and minimize risks of avoidable disease, disability and premature death should be increased. B. The knowledge and capabilities of persons to obtain an adequate diet should be increased. C. Preventive health services should be strengthened as an integral and important part of community and personal health services."

Activities that will help to achieve this goal must place particular emphasis on nutritional care provided by qualified personnel in all communities, urban and rural alike. Nutrition information programs should be developed and pro-

vided by qualified professionals.

There is ever increasing knowledge of the contribution of nutrition and nutritional care to preventive health measures as well as to health maintenance and restoration. When we hope to influence an individual behavior pattern as personal as eating habits we must employ all of the professional resources available.

Health care services should be designed to assure continuity as well as equity of care. Nutritional care has been identified as a prime health care service. Any inequity in providing this service will surely influence the consumers opinion relative to the convenience of care, the coordination and continuity of care, the quality of services provided and the expenditure necessary

to secure adequate care.

We believe that including registered dietitians in the definition of physician extenders permitted to provide reimbursable health care services in rural health clinics can contribute to the delivery of quality health care, provide access to services now denied to a segment of the population and contribute positively to health care cost containment.

ATTACHMENTS 1

Fact Sheet: Nutritional Care-Dietary Counseling.

Position Papers: Nutrition Education for the Public, White House Conference on Food, Nutrition and Health, Food and Nutrition Misinformation on Selected Topics, The Nutrition Component of Health Services Delivery Systems, Nutrition Services in Health Maintenance Organizations.

Policy Statement: Promoting Optimal Nutritional Health of the Population

of the United States.

New Mexico Board of Medical Examiners, Santa Fe, N. Mex., March 21, 1977.

Senator Dick Clark, Chairman, Senate Rural Development Subcommittee, U.S. Senate, Washington, D.C.

Dear Senator Clark: Thank you for inviting me to comment on S. 708, a bill to permit medicare reimbursement of rural health clinics for primary health services. While I am aware of the problems described in the Congressional Record Volume 123, Number 25, I have some concerns about the bill in

its present form.

I agree that the present restrictions on reimbursement under Part B of Medicare requiring that a physician be physically present during the provision of health services by a physician extender, defeats the purpose of these people. However, I firmly believe that S. 708 goes too far in the opposite direction in that it requires no supervision whatever by physicians, only avail-

¹ Retained in files.

ability of consultation services. Presumably the physician extender will decide when consultation is necessary. For proper supervision of physician extenders I do not agree with your statement that an urban area must have a population of at least 50,000. I know of many communities of half that size that have

more than enough qualified physicians to supervise the rural clinics.

I refer to the letter from Bruce G. Anderson of Albert City, Iowa stating that Storm Lake, the county seat and site of the hospital serving his community is 35 miles away. I do not believe that this distance precludes the supervision of the physician extender by doctors in Storm Lake. The extender could maintain contact with the supervising physician by telephone and certainly the supervisor would be able to visit the clinic at frequent intervals, for example three times a week.

New Mexico has a large rural population scattered over vast distances. Physicians' assistants are regulated by the Board of Medical Examiners which insists that all assistants be directly responsible to supervising physicians. Yet we do not require the assistant to be under the physician's roof and he can be located 40 miles or an hours driving time away from him. For your information I enclose a copy of the Rules and Regulations governing physicians' assistants in New Mexico. These have been in effect for several years and have proven, on the whole, satisfactory.

My main concern about S. 708 is that it would create two classes of medical care or, in other words, a feldsher system. I am sure you are aware of the fact that this was tried in Russia and in Czechoslovakia and found unsatis-

factory.

Again I thank you for giving me the opportunity to express my views.

Sincerely,

R. C. Derbyshire, M.D., Secretary-Treasurer.

Enclosure.

RULES PROMULGATED AND ADOPTED BY THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEW MEXICO

Rules 1-17 heretofore adopted by the Board of Medical Examiners, with all amendments thereto, from December 8, 1969 through May 20, 1975, are vitiated and repealed in their entirety and the following rules are now adopted in lieu thereof.

RULE 1

It is against the Board's policy to recommend anyone to the National Board of Medical Examiners for examination.

RULE 2

When a license to practice medicine in New Mexico is revoked or suspended, or other disciplinary action is taken, notice of such revocation, suspension or disciplinary action shall be sent to the Federation of State Medical Boards, the American Medical Association, the Drug Enforcement Administration, state and local medical societies, and all hospitals in the county where the individual involved practices medicine.

RULE 3

All graduates of foreign medical schools applying for licensure in New Mexico shall submit their applications not later than thirty (30) days before the next scheduled meeting of the Board of Medical Examiners.

RULE 4

Institutional permits issued by the Board of Medical Examiners permitting the holder thereof to practice in state institutions will only permit the holder thereof to practice in the institution named in said permit.

RULE 5

It is the policy of the Board to have all applicants for licensure investigated by the Bureau of Narcotics, Biographical Section of the American Medical Association, and the Federation of State Medical Boards of the United States, and inquiry will be made of medical licensing boards and medical societies in other states in which the applicant is licensed, as well as hospitals where said applicant has enjoyed staff privileges at one time or another. In addition, all applicants for licensure must furnish certification as to moral character from their county medical societies. If they are not members of medical societies they must submit two letters of recommendation from physicians duly licensed to practice medicine in the United States with whom they have been associated or under whom they have practiced and submit fingerprints at the time of their application.

RULE (

Internships and residencies are defined as being restricted to internships and residencies approved by the American Medical Association Council on Medical Education and/or the Liaison Committee on Graduate Medical Education.

RULE 7

All foreign medical graduates must have permanent certificates from the Educational Commission for Foreign Medical Graduates before serving as residents or interns.

RULE 8

The Board deems it to be in the best interest of the public to use the examination as prescribed by the Federation of State Medical Boards of the United States (FLEX) in determining the fitness of applicants for licensure by examination in the State of New Mexico. The Board will accept only the weighted average scores of the Federation Licensing Examination as standards for passing in this State, which weighted average must be not less than 75 per cent.

RULE 9

If an applicant for licensure by examination fails his examination he may repeat the entire examination within six (6) months. If said applicant for licensure by examination fails a second examination he will be required to wait one (1) year before being re-examined. A full fee for each re-examination will be charged. No candidate may take the examination more than three times.

BULE 10

No temporary license shall be issued to any applicant until the Secretary has investigated and confirmed the applicant's qualifications to receive such license.

BULE 11

All applicants for licensure by endorsement must file their applications therefor not less than four (4) weeks before a regular meeting of the Board, and those applicants for licensure by examination must file a proper application not less than six (6) weeks prior to a meeting of the Board.

BULE 12

Effective June 1, 1971 and thereafter any application through endorsement must be based on a Federation Licensing Examination given by the State issuing the original license or the certificate of the National Board of Medical Examiners. This will apply to any license presented for endorsement dated June 1, 1971 or thereafter.

BULE 13

Regulations for continuing medical education

1. The New Mexico Board of Medical Examiners requires 150 hours of continuing education every three years. These may be distributed over the period or they may all be obtained in one year.

2. The Board will accept the Physicians Recognition Award of the American Medical Association, the Certificate of Continuing Education of the American Academy of Family Practice and will consider approval of programs of other propositions of the are developed.

organizations as they are developed.
3. In case licensees fail to meet the requirements because of illness or other extenuating circumstances each case will be considered on an individual basis and the Board, when circumstances justify it, may grant an extension of time.

4. Types of credits allowed: I. Required education, II. Elective category type

A, Elective category type B.

At least 60 of the 150 hours must be in required education. The Board will give credit for no more than 40 hours in elective category B. All of the credits can be obtained in required education and credit for up to 90 hours will be given in elective category A if the licensee does not choose to claim credit for elective category type B.

Definitions

A credit hour is on the basis of one clock hour of participation in a continuing education activity.

Required Education

Category 1. Internship, residency or fellowship: 50 credit hours per year during service in American Medical Association approved program for full time training.

Category 2. Education for an advanced degree in a medical field or medically related field: 50 credit hours are allowed for each full academic year of study.

Category 3. Research in lieu of training: Credit is given only for full time research. 50 hours for each full year of research.

Category 4. Continuing education or post graduate courses: A course is considered to be a consecutive series of educational procedures that are planned, coordinated, and organized to meet specific educational objectives for a defined group of physicians or a single physician. Courses offered by any organization or institution listed as course sponsors or co-sponsors should in general meet the criteria defined in the "Essentials of Approved Programs in Continuing Education", published by the Department of Medical Education of the American Medical Association. Courses offered within New Mexico which have not been formally approved by the Council on Medical Education should be submitted to the Board in outline form for review. The average practicing physician will fulfill most of the required education in this category.

Category 5. Teaching: 1 credit hour is allowed for each clock hour of teaching of medical students or physicians in an approved medical school or ap-

proved internship or residency program.

Category 6. Papers or Publications: 10 hours may be claimed for each scientific paper or publication. A paper must be presented to a recognized international, national, regional or state medical society or other organization whose membership is primarily composed of physicians. A publication must appear in a regularly recognized medical or medically related scientific journal. Scientific material used in the paper or publication may be credited only once.

Elective education

Category A. Attendance at recognized State, regional, national or international scientific meetings. 1 hour credit for each hour of attendance.

Category B. Attendance at scientific hospital staff meetings, county society meetings, journal clubs and listening to tape recordings on medical subjects and grand rounds. 1 credit hour for each clock hour of participation. No more than 40 hours will be allowed in this category.

Procedures

1. With the application for re-registration of a license beginning in November 1972 the Secretary will include a form which will require the licensee to list under categories all of his claimed credits for continuing medical education in 1972. Certification will be necessary.

2. When the statements are returned to the Secretary the Board will check them and the credits allowed the licensee will be placed on the record for future

reference.

3. Beginning in November of 1973 with the application for re-registration the licensee will be sent another form similar to the first one. On this form there will be a statement of the hours of credit already obtained. This will be done annually.

4. The end of the first 3 year period will be December 31st, 1974.

RITTLE 14

Rules and regulations governing the issuance of certificates of qualification of physicians' assistants

1. Temporary certificates of qualification will be issued to applicants of good moral character, in the discretion of the Board, who are graduates of physicians' assistants programs approved by the Council on Medical Education of the American Medical Association, the Bureau of Health Manpower Education, or educational programs of the Armed Forces or the United States Public Health Service or their successor agencies which are equivalent, in the opinion of the Board, to the standards promulgated by the Council on Medical Education of

the American Medical Association.

2. All applicants issued a temporary certificate of qualification as aforesaid shall be required to take and pass the examination for physicians' assistants as prepared and given by the National Board of Medical Examiners prior to March 31, 1974, unless otherwise ordered by the Board. If the holder of a temporary certificate fails to take and pass said examination by March 31, 1974, his temporary certificate shall expire, unless extended by the Board in its discretion.

3. Subsequent to March 31, 1974, all applicants for certification as physicians' assistants will be required to take and pass the examination prepared

and given by the National Board of Medical Examiners.

RULE 15

Rules and regulations pertaining to physicians' assistants

The following rules and regulations establishing guidelines for the utilization of the services of a Physician's Assistant are promulgated by the Board for the protection of the public:

A. Relationship of physician's assistant to supervising physician

1. The physician who employes a physician's assistant is totally and absolutely responsible for his actions in the rendering of medical care. This does not mean that the physician's assistant must function only in the office of the physician. But if his duties require that he care for patients in a location away from the supervising physician, he must generally function in reasonable proximity to the supervising physician and have prompt access to said physician by telephone or radio for advice and direction. ""Reasonable proximity" is defined as a location not more than forty miles or sixty minutes from the supervising physician. If the supervising physician is of the opinion that circumstances warrant an exception to this requirement, he must clearly specify them in writing to the Secretary of the Board for the Board's approval of such request.

The supervising physician must visit the premises where the physician's assistant is performing his delegated duties at least three times a week and

more frequently, if necessary.

2. If the supervising physician plans to be absent from his practice for any reason, he cannot designate his physician's assistant to take over his duties or cover his practice during such absence, and it is mandatory that the supervising physician designate a substitute physician to cover his practice and perform his duties. The physician's assistant will be responsible to the substitute physician.

3. A physician's assistant may not prescribe any drugs regulated under the Controlled Substances Act of both the federal and state governments except those drugs enumerated under Schedule V. * * * See attachment amend-

ment * * *

4. A physician's assistant shall not suture any major lacerations. He may suture minor lacerations only after consultation with his supervising phy-

sician, which may be by telephone.

5. The supervising physician shall not delegate responsibility in cardiac resuscitation or tracheal intubation except in emergencies where a physician is not available. These are only two examples of many procedures which constitute dire emergencies and the need of immediate technical knowledge and skill not ordinarily possessed or expected of a physician's assistant. The above examples by their enumeration do not exclude other procedures of equal seriousness. The Board directs all physicians, hospital staffs and governing boards to be specific in their assignment of privileges to the physician's assistant.

6. A physician's assistant may render first aid and apply external fixation to fractures, but he may not manipulate or reduce a fracture when such

manipulation requires local, regional or general anesthesia.

7. In his office practice a supervising physician may assign such tasks to the physician's assistant according to the assistant's ability, always keeping

in mind his ultimate responsibility for the patient's welfare.

8. Although the salary of the physician's assistant may be paid by an agency or person other than the supervising physician, the physician's assistant is to be supervised by one specific supervising physician who is responsible for all of the physician's assistant's acts or omissions. Under no circumstances can a physician's assistant submit a separate bill to any patient of the supervising physician.

9. The Board may, in the exercise of its direction, after investigation and evaluation, place limits on the tasks a physician's assistant may perform, whether under the authorization and direction of a supervising physician or

not.

B. Relationship of physician's assistant to the hospital

10. If a physician's assistant is to be permitted to work in a hospital, the procedures he is permitted to carry out must be carefully and specifically delineated by the Credentials Committee and approved by the proper authorities. The physician's assistant must attest to the rules so promulgated by signing a list of the same which will be filed with and kept of record by the hospital administrator. Broad, all-encompassing statements such as "direct patient care services" or "conduct diagnostic and therapeutic procedures" are unacceptable. Privileges afforded to the physician's assistant must be spelled out in detail and the physician's assistant shall not perform any services or procedures not specifically authorized. It is the duty of the physician's assistant to abide by the rules and the duty of the hospital and supervising physician to see that he does so.

11. The supervising physician or his substitute must countersign all orders of a physician's assistant appearing on a patient's chart, within 24 hours from

the entry of the same.

12. A physician's assistant may not act as a first assistant in the performance of operations which, according to hospital staff by-laws or regulations,

require an assistant surgeon.

13. A physician's assistant may not deliver babies unless he or she has had specific training in obstetrics in a course approved by the New Mexico Board of Medical Examiners and his supervising physician engages in the practice of obstetrics.

I hereby certify that the above and foregoing Rules numbered 1 through 15 inclusive were duly adopted by the Board of Medical Examiners of the State

of New Mexico on November 16, 1976.

AN AMENDED RULE PROMULGATED AND ADOPTED BY THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEW MEXICO

I hereby certify that the requirements of Section 67-26-29, NMSA 1953.

concerning notice and public hearing have been complied with.

Rule 15 A 3, adopted by the New Mexico Board of Medical Examiners on November 16, 1976, is vitiated and repealed in its entirety and the following rule adopted in lieu thereof:

"RULE 15 A 3

A physician's assistant may prescribe any drug authorized in writing by his or her supervising physician, except those drugs regulated under the State or Federal Controlled Substances Act.

The physician's assistant prescribing said authorized drugs shall sign his supervising physician's name on the prescription. When a physician authorizes his physician's assistant to prescribe drugs hereunder he shall furnish a copy of said authorization to the Board of Medical Examiners and the Board of Pharmacy.'

I hereby certify that the above Amended Rule numbered 15 A 3 was duly adopted by the Board of Medical Examiners of the State of New Mexico on

February 21, 1977.

R. C. DERBYSHIRE, M.D., Secretary-Treasurer. THE GEORGIA STUDENT HEALTH ASSOCIATION, MEDICAL COLLEGE OF GEORGIA, Augusta, Ga., March 17, 1977.

DAVID HARF, Office of Senator Dick Clark. Washington, D.C.

Mr. HARF: As a medical student who is concerned with the resolution of health care delivery problems in rural areas I speak strongly in favor of S. 708. My experience in addressing the shortage of adequate services in rural areas has been through the Georgia Student Health Association, an interdisciplinary student organization designed to transfer to rural Georgia communities through screening projects and technical assistance the capability to identify and solve local health and health care problems. This experience has made it patently obvious that physician extenders are a reasonable and viable solution for many communities which are unable to attract or support physicians. Clearly, the prohibition against the payment of Medicare funds for services provided by such professionals when a physician is not present jeopardizes the possibility for health care services in many areas. In fact, those communities most likely to seek such a solution are precisely those areas where a high percentage of the population is elderly or poor and therefore eligible for Medicare or Medicaid coverage but unable to pay for services themselves. Much of rural Georgia fits into this category. Without the passage of S. 708 many communities will therefore be unable to financially support an otherwise excellent mechanism for the provision of primary health care services.

One feature of the bill causes some concern, however. While the shortage of primary services is most severe and the attractiveness of the satellite clinic-physician extender model is most pronounced in rural areas, there is most assuredly a shortage of primary care services in many urban and particularly inner city areas as well. It seems incongrous to limit the applicability of the provisions of S. 708 to rural settings. It would seem more reasonable to extend these provisions to all primary care clinics staffed by physician extenders. Otherwise, another unfortunate provision of Medicare regulations which reimburses providers on the basis of prevailing charges in the area thereby perpetuating a differential in reimbursements for services provided in rural areas as opposed to those provided in urban areas, thus maintaining an inferior level of health care services in rural areas will have been duplicated in reverse.

With the one reservation stated above, S. 708 is a necessary step toward the rationalization of conflicting policies regarding physician extenders. Without its provisions many communities are being denied primary care services of high quality and doubtless efficacy. I heartily support its passage.

> BECKY MERIWETHER. Student Administrator.

SOUTHERN REGIONAL COUNCIL, Atlanta, Ga., March 23, 1977.

Re S. 708.

To: Senate Rural Development Subcommittee:

DEAR SENATORS: As a result of extensive research of health care in the rural South, the Southern Regional Council strongly endorses legislation to eliminate the present prohibition on use of medicare funds to reimburse clinics lacking full-time physicians. We urge that the Senate Rural Development Subcommittee support S. 708, introduced by Senator Clark, Senatory Leahy, and 24 cosponsors, which would accomplish this purpose.

The Southern Regional Council will soon release a report on southern rural development, covering a diversity of areas-including employment, education, agriculture, nutrition, and other issues as well as health care. One specific recommendation made in the report is that, unless and until national health insurance is passed, current programs should be amended to: Designate rural health centers as participating providers under Medicare and Medicaid, with a separate reimbursement policy based on average expenditures of Medicaid recipients and Medicare enrollees in the state.

Such action would help in alleviating the present financial squeeze many

rural health clinics face.

Please enter into the printed record the enclosed chapter on health care, excerpted from the report. This chapter provides more detail on the recommendation listed above, and includes many other recommendations regarding rural health care.

We hope that the subcommittee will react favorably to the recommendations contained in our report, including but not limited to the issue now being con-

sidered.

Thank you for your consideration.

Sincerely,

TIM JOHNSON. Special Program Assistant.

Enclosure.

V. HEALTH

NATURE AND SIGNIFICANCE

Several distinctions can be made between the health problems of the rural South and those of other rural and urban areas. One of the most important of these is the greater prevalence of poverty. Poverty influences the health of people as well as their ability to develop remedial and preventive health programs. In addition, the rural South has a more limited availability of health professionals, particularly medical and dental professionals, than other areas of the country. The rural South also faces problems with poor water quality and sanitation facilities. Inadequate transportation makes it difficult for many people to gain access to health care.

Health problems are more severe in Southern rural areas than elsewhere. The rural South has higher infant and general mortality rates; higher incidences of restricted activity because of health problems; higher incidences of most chronic diseases; lagging nutritional levels; fewer patient care physicians

in relation to population.

The health of rural Southerners is adversely affected by a large number of

important conditions that make improvement difficult.

The high incidence of poverty lessens the ability of people to pay for health

Rural residents are less often covered by private health insurance plans, and the plans they do have are less comprehensive than those of urban residents.

The coverage of public programs is less extensive in the nonmetropolitan

South than in other areas.

While a greater proportion of rural residents is elderly, and Medicare has been of considerable assistance to them, the program sets lower reimbursement levels for physicians practicing in rural areas.

Attracting health professionals, particularly physicians, to the rural South is difficult. Medicare also makes it difficult to develop clinics staffed by nonphysician health professionals who can deliver a limited range of health care to isolated rural areas.

Medical professionals risk professional isolation in rural areas.

The scarcity of health professionals causes those who do locate in rural areas to be overworked and to have limited time for their families and for recreation and professional activities.

Because a minimum population is required to support a physician, low population densities make the establishment of traditional solo medical prac-

tices difficult.

The establishment of rural medical practices can be more expensive. Start-up costs are often increased by the need to build facilities that, in urban places, are usually already available.

Rural areas often lack the cultural, entertainment, educational, and housing

facilities many health professionals want.

Prevailing medical specialization means that fewer doctors are available to rural areas because rural population densities are not ordinarily great enough to support specialists.

The medical system and legal restrictions on the practice of medicine also constitute important obstacles to the establishment of rural health systems. Although the medical system in the United States has never been monolithic, and there are trends toward a higher number of primary care physicians, the medical profession has embraced several dominant values that discourage

rural practice.

The critical importance of specialization needs to be emphasized. Between 1940 and the 1960s, an increasing proportion of medical care was delivered by specialists who required dense populations and a close association with medical centers. Rural areas are not attractive to specialists, and specialists are usually not appropriate for meeting the health care needs of an entire rural population.

Similarly, there has been a proliferation of medical technology, much of which also must be located in urban places, or dense medical centers, to be

used effectively.

Health care for blacks, Mexican-Americans, and other minorities is impeded by insensitivity and by discriminatory practices found in many rural medical facilities. Some physicians still maintain segregated waiting rooms, and black patients are restricted to certain hours of the day in seeing private physicians. These and other such practices are burdensome for rural poor people who have few alternative sources of health care.

NEW APPROACHES TO RURAL HEALTH CARE

Several new approaches to health care in the rural South seem especially promising. These include:

Comprehensive health centers providing a wide range of health and health

related services.

Nurse practitioner or physician assistant primary care centers. New types of group medical practice and team approaches.

Innovations in health professional education, such as: area health education programs; communications systems linking rural physicians with rural and urban health centers; emphasis on preparation of students for rural practice; designing new roles for non-physician health personnel; and family practice

residency programs.

One of the major difficulties with traditional medical practice in rural areas is the instability created by the loss of a physician. While the turnover of a few health professionals may have no noticeable impact on a large urban area, rural communities having fewer professionals to start with are more vulnerable. Several approaches have been developed to help bring about more stability to rural practice in the South. These approaches include the creation of a community organized and controlled non-profit corporation that takes the responsibility for attractive health professionals and maintaining a stable health care center. Other approaches use health providers in nearby larger communities to sponsor primary health care centers in rural communities.

Community or consumer-sponsored rural health projects have a number of advantages. One of the most important is the indigenous leadership base for the development of medical facilities that such a project provides. The development of a successful community or consumer-sponsored rural health project also can have beneficial psychological effects on a community. Community involvement in a health project probably helps to insure its success by stimulating larger community use of the facility. Community sponsorship can lead medical practitioners to be more concerned with preventive and environmental health problems. Preventive medicine is essential. It does little lasting good to treat diseases if nothing is done about the underlying causes of those diseases. A medical system operated entirely by medical professionals is less likely to emphasize broader environmental and preventive problems.

Sponsorship of rural health systems by area medical schools is another approach. This approach has the advantage of obtaining physicians for towns that could not attract their own. Medical students, exposed to rural practice through this means, may develop greater inclination to practice in rural areas. Participation in a rural health project might also induce some changes in a medical school, increasing its responsibilities to rural health needs—either

through changes in admission policies or in curriculum.

Sponsorship by a medical school also can have disadvantages, particularly the instability created should the school withdraw its support. In addition, patients may complain of the time it takes to be seen by a medical student and also by the staff physician, and may feel uncomfortable because of the number of persons attending the cases. Medical school-sponsored health projects also are more likely to take a less comprehensive, primarily medical, approach to health than are community-sponsored projects.

ALTERNATIVE MODELS OF RURAL HEALTH DELIVERY

Innovative approaches to rural health also reveal considerable diversity in the range of services provided and the mix of professionals used. Three major types, however, seem to offer the most hope for improving rural health among the approaches examined by the Task Force's special Rural Health Project. These are: (1) comprehensive health centers that do more than provide just medical care; (2) health centers staffed primarily by nurse practitioners or physician assistants; and (3) group practices, consisting of two or more primary care physicians or a team including physician and non-physician health professionals.

Each of these models has advantages and disadvantages for different circumstances. The main advantage of the comprehensive health centers are their ability to address a wide range of medical problems and the ability to reach populations not ordinarily served by traditional medical facilities. These traditional facilities in the rural South have been established largely to serve low-income people or minorities. Ideally, comprehensive health centers offer

the best hope for total health care to the poor.

The main disadvantage of the comprehensive health centers so far has been their cost. The total cost per "encounter" in many projects averages \$35-40, as compared to \$15-20 in more traditional medical projects. The medical cost alone, however, in the comprehensive health centers, is roughly \$20 a visit, which is competitive with other types of providers. Because these centers have relied heavily on government and other outside sources of funding, the uncertain financing becomes a major disadvantage.

Health centers staffed with non-physician health professionals (such as nurse practitioners, physician assistants, and nurse midwives) are another approach to primary health care in rural areas. They have been remarkably successful in recruiting and retaining professional staffs. For example, of the 90 nurse practitioners trained at the University of North Carolina before 1975, only seven failed to return to the rural area they had agreed in advance

to serve.

Nurse practitioner health centers are relatively low-cost operations. In contrast to the comprehensive health centers (whose budgets may run from \$500,000 to \$4,000,000 a year), centers staffed by one or two nurse practitioners and part-time physicians have average annual budgets in the range of \$60,000 to \$80,000. As a consequence, many rural communities that are too small or too poor to support a more expensive system can at least have this type of

primary health care.

The approach, however, has some disadvantages. One of these is the reluctance of major third-party insurance programs to pay for services rendered by nurse practitioners when a physician is not physically present. Medicare does not pay for services under these conditions. Even those states covering these services under Medicaid require the payments to be made directly to the sponsoring physician rather than to the health center. This requirement necessitates a negotiated agreement between the health center and the physician which has often favored the physician.

Other potential difficulties for this health model are more long-range. Rural health centers, staffed by a single nurse practitioner, eventually may face the same difficulties currently confronting solo-physicians. Demands on their time can become overwhelming. The nurse practitioners can find themselves unable to keep abreast of professional developments that would improve their competence. Also, the degrees of acceptance by the medical profession of the roles

and duties of the nurse practitioners remain uncertain.

The third model is group medical practice. While these practices vary considerably, their common characteristic is provision of medical services by a

group of primary care physicians. From the experience in the rural South to date, acceptance of this approach by physicians is favorable. Group practices can overcome most of the professionals' objections to working in rural areas, including the long hours, heavy demand, and professional isolation. The approach can provide time off for physicians to pursue continuing education. Physicians in the group and their families also form their own social unit, or the nucleus of a larger social unit, thus overcoming some of the isolation professionals often feel in small towns and rural communities. Emphasis upon good management provided by non-physician trained administrators is another major strength of the team approach.

Yet the team approach has potential disadvantages, too. There is the temptation to emphasize profit-making medical problems to the neglect of less profitable environment or other factors causing poor health. Emphasis on economic self-sufficiency also can lead to less sensitivity to the needs of poor people,

so that the more affluent benefit most.

There have in recent years been several trends in medical education and in the training of non-physician health professionals that could make medical techniques and practice more amenable to rural needs. A promising approach is development of communications systems to connect family physician specialists with other practitioners, including those at medical schools. Such communications systems can do much to break the professional isolation of rural practitioners. There also has been a significant increase in family practice residences in medical schools and hospitals since the middle of the 1960s. The number of family practice programs increased from 30 in 1969 to 260 in 1975, and is expected to reach 340 in 1975. A fairly large proportion of family practitioners locate in rural areas.

HEALTH PLANNING

The National Health Planning and Resources Development Act of 1974 creates an elaborate and complicated mechanism for health care planning at federal, state, and local levels. It also provides for greater consumer involvement than was true of previous federal health programs.

Of particular significance for rural people is the provision that at least 25 percent of any state's funds for loans, loan guarantees, and interest subsidies for construction or conversion of medical facilities, must be used for outpatient facilities serving medically underserved people. Half of this money is

specifically designated to meet the needs of the rural underserved.

This new law also creates a nationwide network of approximately 200 health service areas. A Health Systems Agency (HSA) is given responsibility for area-wide health planning in each area. The localities represented by these agencies are designated by the governors of the respective states with approval by the U.S. Department of Health, Education, and Welfare.

The main purposes of an HSA are to:

Improve the health of the residents of the area.

Increase accessibility, acceptability, continuity, and quality of health services.

Restrain increases in costs of health care. Prevent unnecessary duplication of services.

Each HSA will assemble data to analyze health status and facilities in each area, formulate annual health and implementation plans, establish "area health services and development funds," and review, and approve or disapprove, all federal grants made under the acts that fund the Public Health Service, the Community Mental Health Centers, and the Comprehensive Al-

cohol Abuse and Alcoholism program.

RECOMMENDATIONS

The need for improved rural health care is evident and many new and innovative ways to seek it have been described. Policy changes are needed in the training of health professionals, in the nature of rural practice, in the content of rural health care, in the way minorities are treated, in the way rural health care is financed, in planning for better health.

Training health professionals

Greater emphasis needs to be placed on training physicians and other health professionals specifically for rural practice.

Special programs should be established to acquaint medical students with rural health problems and medical practice.

States should support the establishment of health education centers and

family practice residencies in rural areas.

Greater support should be given to the development of broadly-trained non-

physician health professionals.

Admission and scholarship procedures of medical, dental, and nursing schools should be reviewed to ensure that students desiring rural practice are sought and that such students are familiar with sources of financial support for education.

Changing the nature of rural practice

While more experience is required to know with certainty those changes in rural practice that will be most successful in attracting qualified health professionals and in improving rural health, the following components for a rural health system are recommended:

Group practice should be established where needed to prevent social, cul-

tural, and professional isolation and overwork.

Nurse practitioner clinics with backup part-time physician support should be organized within smaller communities that cannot support or attract groups of physicians. Such clinics should be sponsored by stable community organizations.

Legal support and technical assistance should promote the effective use of non-physician health professionals. State nurse practice acts and medical practice acts should be amended to permit nurse practitioners with appropriate training to treat patients and write prescriptions, subject to requirements of physician supervision, written protocols, adequate auditing of nurse practitioner performance, and continuing education. Such nurse practitioners should be permitted to see patients without the physicial presence of a physician, if the backup physician is available by telephone for consultation and such physician participates in a continuous auditing of nurse practitioner performance.

Programs should be adopted to help meet the start-up costs of establishing rural group practice, if these practices meet certain conditions required for

effective rural health care delivery.

Ideally, rural health care should be part of a system that:

(1) Extends care into remote areas either through outpost clinics or the use of mobile facilities.

(2) Relates the particular practice to hospitals, laboratories, and other specialists in rural or urban areas.

Provisions should be made for the continuing education of health professionals involved in rural practice. Periodic attendance at conferences and short courses, seminars held within the area, and interaction with medical school staffs would be helpful.

Special attention should be given to the establishment of management systems for health centers. As a number of such systems are available, each should be studied carefully to develop a model for particular practices. A skilled administrator should be made an integral part of every rural health center.

Changing the content of rural health care

Rural health practice should be concerned with environmental health and preventive medicine. Because of the conflict between a primary concern for providing medical care, and attention to environmental health problems and community affairs, private medical professionals may or may not provide the leadership for environmental health and preventive medicine. Therefore:

(1) Non-profit corporations should be established with community representation on their boards of directors to create concern for environmental

health problems within medical practices.

(2) Government or privately supported community organizations should help bear the costs of community outreach programs and transportation facilities that are needed to improve the access of rural people to medical care. The benefits of such services to a community at large justify such assumption of some of these increased costs.

Special attention needs to be given to meeting the dental care and mental

health needs of rural people.

Rural areas have a much higher proportion of elderly people, and the incidence of chronic conditions of confinement to beds is much greater in the rural South than other areas. Emphasis should therefore be placed on home health services for the rural, homebound elderly.

Because of low educational levels, many rural residents are unfamiliar with

Because of low educational levels, many rural residents are unfamiliar with good health habits. Effective patient health education, including provision of printed materials and visual aids as appropriate, should be a part of rural

health care.

Since preventive care has been long neglected in rural areas, special emphasis should be given to well-baby care, immunizations, contraceptive information, cancer screening, and prenatal services.

Minorities and rural health care

Affirmative action in health training and federal health programs has attracted relatively few members of minorities into the health professions. Few minority women have been trained in the nurse practitioner training programs. The National Health Service Corps has few minority health professionals. Because attitudes toward personal achievement are important to mental health, successful minority health professionals can be important in demonstrating to rural minorities what minority persons can accomplish.

The available evidence suggests that several additional steps can be taken

to improve health care for Southern rural minorities.

A systematic study should be made of the extent, severity, and forms of discriminatory or exclusionary practices in the provision of health care in Southern rural areas, in the training of health professionals for those areas, and in the administration of federal, state, and local health care programs.

Local medical societies should not be permitted for discriminatory reasons

to thwart federal or state rural health projects.

The National Health Service Corps should conduct a more intensive affirmative action program by providing additional scholarships to members of minority groups for medical training and by otherwise increasing the placement of health professionals in rural areas, toward the goal of augmenting the number of qualified Spanish-speaking and black health professionals working in the rural South.

The Medicare program should enforce non-discriminatory practices in the provision of hospital care, nursing home care, private physician care, and

other covered services.

Programs to increase the sensitivity of health professionals dealing with minority groups should be improved and undertaken.

Changing the financing of rural health care

Federal and federal/state health programs have proved to be of limited assistance to rural Southerners—as compared with other segments of the population. Changes in existing programs, and implementation of new ones designed with rural areas in mind, are required to correct the imbalance in present policies.

Implementation of national health insurance would benefit rural residents who have inadequate coverage under private health insurance and public programs. Specific features that would help insure that rural residents receive

a fair share of benefits include:

(1) Establishment of fee schedules for physicians that reward rather than

penalize physicians for practicing in underserved areas.

(2) Reimbursement for services of non-physician health professionals at rural health centers, whether or not a physician is physically present when service is rendered.

(3) Recognition of community-sponsored rural health centers, ones that meet specified standards, as providers of health services eligible for direct reimbursement.

reimbursement.

(4) Coverage of all people regardless of family composition, eligibility for

welfare, employment status, or other conditions.

(5) Creation of health resources development boards with funds to induce specifically needed health personnel to locate in rural communities and to help develop innovative approaches to health care delivery in rural areas.

(6) Development of supplemental programs to overcome specific barriers to improved health in rural areas. Ameliorative programs would include transportation services, outreach services, and patient education services.

If existing financing programs are not replaced by national health insurance, the following amendments to current programs would provide much needed relief to rural residents:

(1) Designate rural health centers as participating providers under Medicare and Medicaid, with a separate reimbursement policy based on average expenditures of Medicaid recipients and Medicare enrollees in the state.

(2) Revise the Medicaid program to include low-income, two-parent families regardless of welfare or employment status. Require all states to cover rural

health center servics and the medically needy.

Comprehensive health centers currently funded by the U.S. Department of Health, Education, and Welfare should be maintained rather than cut back as proposed by some. Medicare and Medicaid programs should be amended to permit comprehensive health centers to receive capitation payments from these programs based upon average expenditure levels for all persons covered by Medicare and Medicaid in the state.

The National Health Service Corps should continue to experiment with approaches to rural health care, including greater emphasis on nurse practitioner clinics, group practices, a larger role for community residents in the management of health services, and better technical assistance to the Corps'

own activities.

Health planning

Persons interested in rural health problems need to pay particular attention to the National Health Planning and Resources Development Act of 1974. The Act may offer significant changes for the delivery of rural health care, and every effort should be made to make its provisions of maximum benefit for rural people. Approval of federal funding for a health project in general, and approval of a certificate-of-need in particular, will depend on how well a proposed rural project fits area and state plans. Moreover, National Health Planning and Development Agencies might be able to provide much useful information, technical advice, and coordination, and even planning funds for rural health facilities.

VERMONT STATE NURSES ASSOCIATION, INC., Burlington, Vt., March 16, 1977.

Senator Patrick Leady,

Suite 7B, Russell Office Bldg., Washington, D.C.

DEAR SENATOR LEAHY: The Vermont State Nurses Association wishes to take this opportunity to thank you for your continuing efforts to improve health care in rural areas and for the interest you've shown in nursing's contribution to the health care system.

S. 708 is a major step in allowing those in rural areas an improved access to health care. We hope hearings can soon be scheduled and action taken on

the bill.

The Vermont State Nurses Association is very hopeful that at the time of hearings you can play a major role in perfecting the bill's language so that the terminology of "physician extender" can be improved upon and clarified. As you are aware, nurse practitioners bring to the system not only their more recently acquired knowledge in the patient's physical assessment but also the education and experience of registered nurses. This means they are uniquely well qualified to meet nursing needs. These nursing needs encompass prevention of illness, adaptation to illness, maintenance of health and patient education. These independent nursing functions must be reimbursed to assure that patient care.

In addition the nurse is uniquely qualified to identify pathology and deviations from the normal state of health. The pathology and deviations from health can then be handled through previously established nursing/medical protocols and/or then be referred to the expert in pathology—the physician—for evaluation, consultation and assistance in formulating a treatment plan.

The nurse is licensed and is responsible for his/her practice under the state Nurse Practice Act. The physician's assistant is not licensed and, no doubt, much more closely fits the description of "physician extender" for he/she must function under the supervision of a physician.

For these reasons, the Vermont State Nurses Association could not support legislation which promised to equate nurse practitioner and physician's assist-

ant services as one and the same. We feel sure this is not the intent of the bill, and that further clarification can be accomplished by separating out the

term nurse practitioner from physician extender.

We should also add that (C) under Section (2) which defines rural health clinics gives us some cause for concern. Since nurse practitioners in Vermont work collaborately with the physician to develop protocols (medical orders) we wonder if the bill's language doesn't, in actuality, continue to restrict reimbursement only to the "supervised medical realm". We urge that the word "supervising" be struck and secondly that instead of "medical orders" the language read "health care orders".

The definition of physician extenders as defined in S-708 mentions only Adult and Family ANA Certified Nurse Practitioners. This definition needs to be broadened to include nurse practitioners with any specialization who are certified according to ANA Guidelines, e.g., pediatric and gereatric nurse

practitioners.

Also, we suggest that as a part of (2) (H), more emphasis should be placed on quality by including a requirement for a multi-disciplinary audit in addi-

tion to the utilization review.

We sincerely hope our comments are helpful as we all strive to provide rural America with a comprehensive and high quality health care delivery system. If we can be of assistance as this legislation is being considered please let us know. Thank you for your leadership in the past, for co-sponsoring S-104 (reimbursement for services of RN's) and we look forward to hearing of your fruitful efforts to modify and clarify the afore mentioned language in the rural health clinics bill.

Sincerely.

CAROL FIELDER, R.N.

THE PENNSYLVANIA STATE UNIVERSITY, College of Agriculture, University Park, Pa., March 24, 1977.

Hon. DICK CLARK, Chairman, Senate Rural Development Subcommittee, U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: In accordance with your request, I am sending my views on your bill (S. 708) which would permit Medicare reimbursement to rural health clinics for services provided by nurse practitioners and physician's assistants. Except for one concern, which I will mention later, this bill has

my enthusiastic support.

During the past several years I have participated in innumerable conferences, workshops, and meetings in which various proposals for alleviating the rural health problem have been discussed. With one exception, every proposal has generated considerable, and sometimes bitter disagreement. The exception is the unanimity expressed for third-party reimbursement for services rendered by nurse practitioners and physician's assistants—even when these services are rendered in the absence of a physician's direct supervision. To wit, S. 708 is consistent with the position of the American Medical Association and the recommendation generated at the 1975 Conference on Rural America and the 1976 Southern Rural Health Conference. 1 2 3

I suspect the exclusionary reimbursement provisions in the existing Medicare legislation was included out of a genuine concern for ensuring the delivery of high quality health care. It is unfortunate that this concern resulted in a universal judgment about an entire group of personnel involved in the delivery of health care. In short, the stipulation that Medicare will reimburse for services only when they are delivered under the direct supervision of a physician does not ensure quality—especially if the supervising physician is incompetent! If the concern is with quality, such mechanisms as Professional Standard Review Organizations should be further strengthened to evaluate the "final product" of the care delivered by individual practitioners—regardless of whether these practitioners are nurse practitioners or neurosurgeons.

Much research has been undertaken on the feasibility and desirability of making greater use of "new health practitioners", including nurse practitioners and physician's assistants. The conclusion that consistently emerges is that these practitioners have considerable potential for increasing the supply of

health services and decreasing their cost.4

Although nurse practitioners and physician's assistants have a crucial role to place throughout the health care delivery system, they have a particularly promising role in rural areas because rural areas currently have fewer health care resources and in many cases cannot support a full-time physician. Even in those cases where a rural community can support a full-time physician, they often have difficulty in attracting and retaining a physician. These communities may not have as much difficulty in attracting and retaining nurse practitioners and physician's assistants. For example, Davis and Marshall found that only 7 out of 90 nurse practitioners trained at the University of North Carolina failed to return to the rural area which they agreed to serve at the beginning of their graduate training.⁵

Of course it would be naive to suggest that S. 708 will solve the entire rural health care problem. However, it will do two essential things. First, it will enable the elderly to have greater access to health services being provided by nurse practitioners and physician assistants in those states which do not require direct supervision of a physician. Second, in these states it will lead to the establishment of additional clinics in areas that cannot currently support clinics because they are unable to receive Medicare funds. The establishment of clinics in these areas would obviously benefit persons other than just the

elderly.

The importance of Medicare reimbursement in providing the margin of financial support needed to ensure viability for rural health clinics should not be underestimated. A detailed study of an Oklahoma clinic manned by physician's assistants found that the clinic was medically feasible but was an economic failure. Moreover, the evidence strongly suggested that the inability of the clinic to receive Medicare reimbursement was a fundamental reason for its financial failure. This should come as no surprise whe none realizes that rural areas have a relatively large percentage of elderly. In addition, community owned and operated clinics typically serve a disproportionately large share of the elderly—especially in communities where privately practicing physicians refuse to accept Medicare patients.

The effect then, of enacting S. 708 is quite clear in those states where nurse practitioners and physician's assistants can currently deliver services in the absence of the direct supervision of a physician. But what about in those states where state statutes effectively prevent nurse practitioners and physician's assistants from delivering services unless a physician is giving direct supervision? In these states, S. 708 will provide an incentive for states to repeal these

restrictive statutes.

My arguments in support of S. 708 assume that patients and those in the medical profession are willing to make effective use of nurse practitioners and physician's assistants. Fortunately, this assumption is supported by extensive research findings. For example:

1. Leadleys' survey of rural adults in Pennsylvania found that 90 percent of adults would willingly accept medical help from a physician's assistant.

2. McCoy, Green and Grinstead's Arkansas study found that 63 percent of those persons 65 years of age and over would willingly use a physician extender.⁸

3. Lairson and his colleagues at the Kaiser Foundation found that physician's assistants were generally well accepted by physicians, nurses, pharma-

cists and patients.9

4. The American Academy of Pediatrics found that over one-half of the pediatricians they surveyed believed an allied health worker should make home visits in follow-up of acute illnesses and for patients with chronic disease, and should provide medical advice on minor medical matters.¹⁰

5. Fottler and Pinchoff found that only 8 percent of the health care administrators they surveyed felt a nurse practitioner would not be an asset to their

institution.11

It seems to me that the arguments are overwhelming for permitting Medicare reimbursement to rural health clinics for services provided by nurse practitioners and physician's assistants. What is not as clear is how the level of reimbursement should be determined. I would argue strongly for reimbursement on the basis of the cost of providing services. However, this approach, in purist form, does not provide an incentive for cost containment and efficience.

ency; and must therefore be supplemented with appropriate guidelines, and/or other types of incentives (such as prospective reimbursement) which will ensure efficiency in the delivery of services. The alternative to reimbursement on the basis of cost is to base the level of reimbursement on "prevailing" fees or charges. Unfortunately, the market for health services is so imperfect that there is often times little relationship between the cost of providing services

and the prevailing fees for those services.

Finally, I would like to comment on the only significant reservation I have about S. 708. This reservation is the failure of S. 708 to extend Medicare reimbursement to physician's assistants and nurse practitioners in urban areas. Although these personnel have particularly promising roles to play in rural areas, I see no good reason to confine their potential to rural areas. Surely, urban residents should also be allowed to benefit from the decreased cost and increased accessibility that can result from more extensive use of physician's assistants and nurse practitioners. In short, if quality health services are being provided and the consumer is satisfied with those services, then the provider should be reimbursed regardless of whether she or he practices in a rural or urban area.

Let me close by thanking you for the opportunity to express my views. Please

feel free to call on me if I can be of additional assistance.

Sincerely,

SAM M. CORDES, Assistant Professor.

Enclosure.

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> COMMUNITY HEALTH CLEARINGHOUSE. Seattle, Wash., March 16, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. HARF: The Community Health Clearinghouse was formed three years ago to deal with health manpower maldistribution issues in Washington State. It assists medically underserved communities with health manpower needs assessment, design of practice arrangements, recruitment of primary care practitioners, and retention of these once they are attracted to a practice site.

As Director of this agency which works daily on the problems of improving health services in rural areas, I am writing to strongly support legislation aimed at allowing Medicare reimbursement to rural health clinics for primary

health services.

At a recent Rural Health Conference sponsored by a number of concerned organizations in Washington State, reimbursement problems were identified as one of the key barriers to new developments in rural health care delivery. Our office confronts this barrier every time we consult with a community group which wishes to investigate the possibility of establishing a primary health clinic using Nurse Practitioners or Physician's Assistants.

Please enter this supportive testimony in the printed record of the hearing

on S. 708 to be held March 29.1 Thank you.

Sincerely,

M. J. Crigler,
Director.

UNITED CHURCH OF CHRIST, OFFICE FOR CHURCH IN SOCIETY, Washington, D.C., March 18, 1977.

Hon. Dick Clark, Chairperson, Rural Development Subcommittee, U.S. Senate, Washington, D.C.

Dear Senator Clark: The United Church of Christ and its predecessors has held a great concern for rural development for the time when Boston was a village precariously surviving in the wilderness. It has also held a deep concern for health care as may be demonstrated by the more than eighty health care facilities associated with the United Church Board for Homeland Ministries. While no one person or group can speak for the entire 1.8 million membership of the United Church of Christ, the Office for Church in Society has been charged with the responsibility to interpret the public policy statements of the General Synod, the national delegate body of the United Church of Christ.

In its 1975 "Resolution on National Health Care Policy the General Synod stated:

The achievement of better access, effectiveness, and efficiency in the maintenance of health and the delivery of health services requires improved planning and organization of services to assure complete geographical coverage, and a structured interrelation of preventive services, primary care, specialized care,

and other dimensions of health care.

On the other hand, within national standards, there must be sufficient flexibility to permit adaptation to local health needs, wishes, and cultural patterns and to permit innovation in both the organization and the delivery of health care. This includes the flexibility to permit a variety of public and private auspices and mixes in the administration of health care in a given area. Special efforts should be made to preserve and enhance the elements of voluntarism and religious and humanitarian motivation to service which have characterized many sectors of the present health care system.

Under the present nonsystem of health care in the United States, access to primary health care services in rural areas is a chancy proposition. According to the American Medical Association, there are 134 counties in 36 states with-

out a doctor.

For most medical needs, the extremely high level of training which a physician has is unnecessary. They can be appropriately handled by a physician extender in a primary care clinic linked to a physician and hospital where persons needing higher levels of care can be referred. This system has been successful for years in the armed forces of the United States, particularly in combat situations where there have been high incidences of need for various levels of immediate medical care.

Physician extender system of medical care, however, cannot be utilized by elderly people covered under Medicare. For many, particularly those in rural

¹ Retained in files.

areas, these are the only practical means of obtaining medical care. If such a system is good enough for armed forces personnel in combat, why shouldn't it be good enough for elderly people in rural areas?

The present Medicare law says that it isn't. The proposed bill S. 708 would change the Medicare law to say that it is. If enacted, it will be a great

advance for elderly people in rural areas.

But what about the rest of the people in rural areas? Any health care coverage which they might have will vary widely in whether or not physician extender primary care is covered. National health insurance is coming. It will be essential that whatever NHI law is passed contain language similar to that contained in S. 708. Otherwise, advances made for Medicare recipients will be lost again when the general population is covered.

Sincerely.

FREDERICK L. HOFRICHTER. Associate, Legislative Concerns.

COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF AGRICULTURE, Harrisburg, Pa., March 25, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. HARF: Regretfully, your request for written testimony did not reach my office until late last week when I was committed to several out-ofoffice conferences. Therefore, I have not had time to properly research and prepare a statement for inclusion in the record that would properly describe

the Pennsylvania position.

However, I can state, in general terms, that we who work with the citizens in the small towns and rural Pennsylvania are constantly aware of the need for adequate health care facilities and the means of transportation to reach them. Small communities throughout Pennsylvania are faced with the problem of securing physicians to practice in their area. As in other areas of the United States health care providers are concentrated in our urban-suburban centers.

Legislation such as S-703 can only be effective if the state legislatures do their part and allow for licensing of nurse practitioners and physician's assistants. Restrictive legislation in many states would prohibit the type of rural

clinic service envisaged by S-703.

In the interests of providing quality health care with proper supervision, I believe the bill provides adequate safeguards as far as physician supervision and record-keeping. I can see some problems if the extenders, in their zeal to emphasize preventive health care, become more attuned to the "social service" aspect or approach to their role than to actual direct provision of examinations and supervised delivery of health care.

Certification procedures could best be administered by the states under guidelines being developed by the Federal Government.

I'm sure health care would become more available in rural areas if S-703 is adopted.

Very truly yours,

JANE M. ALEXANDER. Secretary.

STATEMENT OF THE NATIONAL COUNCIL ON THE AGING, INC.

The National Council on the Aging appreciates the opportunity to express its views concerning the Rural Health Clinic Bill. We believe much of the information we are presenting will not be duplicated by other testimonies since its primary focus is not on Title XVIII nor on physician extenders but rather that segment of the population to which this bill addresses the older

From its inception, nearly 27 years ago, NCOA has demonstrated its interest in the rural older American. Within its structure, the NCOA Board of Directors has a special Committee on Rural Aging composed of Board members representing geographical rural areas. This committee has a substructure. NCOA Rural Coalition, whose membership comes from our constituents who

are directly involved in providing services in rural areas.

There are many ways in which we reach our constituents. One of the most effective is through the NCOA Annual Conferences and regional meetings. The list of rural topics at previous meetings is voluminous. This year, for example, the Annual Conference topics include "Medical and Health Services for the Rural Elderly" and "An Introduction to National Rural Organizations and the Agencies.

Pertinent to this bill, NCOA was responsive to a challenge from the Office of Economic Opportunity in 1966 in conducting a national program, "Medicare Alert," to reach persons who had not signed up for Medicare. Many of the areas we reached were rural communities. Following this, a landmark study, Project FIND (Friendless, Isolated, Needy and Disabled) was implemented and in essence destroyed many of the myths about the aging. The rural older adult is reflected over and over again in the results of this study. Because of this study and results of various project experiences, NCOA is frequently called upon to provide information to legislators through our Public Policy Department and has testified before such groups as the Special Committee on Aging, U.S. Senate; i.e., hearings on the Older Americans Act and the Rural Aging. Our program units, the National Institute of Senior Centers, National Voluntary Organizations for Independent Living for the Aging, National Institute of Industrial Gerontology, National Center for the Arts and Aging, and Senior Center Humanities Program respond daily to the requests for technical assistance, consultation, informational and referral services from rural areas across the country.

NCOA has observed the growth of public services in response to the increasing needs of the elderly for many years now. Demographic projections predict an ever-increasing and changing older population—one which will require a more flexible and comprehensive health care system to meet its

needs.

Between 1960 and 1970, older Americans increased in number by 21 percent as compared to 13 percent for the population under 65 (a further 12 percent versus 4 percent in 1970–1975). The 65+ population of 22,300,000 in 1975 is expected to increase to more than 30,000,000 by 1995, while the 75+ population of 8,449,000 in 1975 is expected to increase to almost 12,500,000 in 1995. As a result of this predicted increase in the population, there are some very significant problems associated with the area of health care and also in the area of obtaining health services.

Current health problems associated with the aging process will not decline,

but more likely will increase as does the ensuing elderly population.

In a U.S. Senate Special Committee Report, *Developments in Aging: 1975 and January-May 1976*, it is disclosed that older Americans are subject to more disability, see physicians 50 percent more often, and have about twice as many hospital stays that last almost twice as long as is true for younger persons. Moreover, the elderly are more likely than their younger counterparts to suffer from multiple, chronic and often permanent conditions which may be disabling. Concurrently, as elderly people with severe chronic conditions survive longer, the requirement and necessity for available and accessible health care and services for the elderly population will also need to increase. As a result, we must be cognizant to the fact that there is and will be a growing need to develop and implement alternative mechanisms in delivering health services to the elderly population. One particular mechanism would be the physician extender.

The issues addressed above point out some startling as well as interesting topics for discussion and discourse. We must consider some important issues which emphasize the growing need for the development of alternative mech-

anisms in the delivery of health services.

As we have seen, the proportion of people 65–69 is getting smaller while the proportion of those 75+ is getting larger; and the prevalence of chronic disease and impairments increases sharply with age. Therefore, this increasing older population will need more outpatient physician care services and in some cases home services so they can continue to lead active worthwhile lives. As the population increases, the rate of utilization of health services should also rise.

In considering the merits of this bill, one must also consider the health conditions and the population target group it is to serve. While the above data may surprise you, when one looks at the number of older Americans living in rural areas, the situation becomes even more critical. Older Americans constitute one out of five persons residing in rural America. Proportionately, there are more older Americans living in rural areas than there are in urban areas. According to data from the National Health Survey, by age 65 eight out of every ten rural individuals reported a chronic condition, and the proportion is higher for farm than nonfarm residents. The most salient of these ailments among the rural elderly were arthritis and rheumatism, heart conditions, and high blood pressure; hearing problems constituted the most important impairment. Furthermore, there is a lower occurrence of injuries for urban older adults compared to those living in rural areas. In general, it appears the physical health conditions appear to be more favorable for the urban older adult compared to the older adult living in rural areas.

Clearly, addressing the health needs of the rural older American encompasses making services available and accessible. NCOA believes the Rural Health Clinic Bill is a very important measure in dealing with the problem. It is a well documented fact that there is a continuing acute shortage of physicians in rural areas. During the First National Conference on Rural America in 1975, it was reported that overall the United States averages one doctor for every 781 persons; in rural areas the ratio is nearly double—one doctor for every 1,400 persons. According to the Health Resources Administration, rural counties in 28 States have experienced a decline in the number of physicians for the period 1960 to 1972. In addition, the matter seems even graver when one considers a report that less than one percent of the medical school graduates who graduated during the period 1960 through

During July 1976, the House Ways and Means Subcommittee on Health held hearings in Knoxville, Tennessee. The subcommittee heard warnings that unless Medicare regulations concerning the payment of physician extenders are changed, dozens of the rural extender clinics, which are supported by Federal, State and private grants, stand to close in the next year as these funds will expire. Medicare beneficiaries frequently represent 25 percent to 50 percent of the visits made to these clinics. Physician extenders play a vital role in reaching older rural Americans. The potential of their services has not fully been realized and probability of utilizing their services is seriously threatened when one considers that their willingness to locate in underserviced areas is being arrested because in part, their services are not reimbursable by Medicare.

In closing, the National Council on the Aging sees a double jeopardy facing rural older Americans—being in poor health and living in rural America—unless public action is taken soon. It is ironic that those who were the backbone of this Nation are being neglected in receiving a basic right—a right to have easily accessible and flexible medical services.

We hope the Committee will seriously consider Medicare reimbursement of physician extenders as a response to the critical need for additional health

services for the rural older Americans.

STATEMENT OF THE COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES, NATIONAL LEAGUE OF NURSING

The Council of Home Health Agencies and Community Health Services is the national spokesman for 1,500 home health agencies and community nursing services. These agencies provide health services to people outside of hospitals; in other words, in patients' homes, in schools, public health clinics, and other

community settings.

CHHA/CHS supports the intent of S. 708 dealing with Medicare reimbursement of health services provided in rural health clinics. It is gratifying to see one more barrier removed in making quality health services more available to rural populations. The effort to make more appropriate use of physician assistants and nurse practitioners in developing systems of primary care is commendable. There are a few comments and recommendations we wish to make which relate primarily to clarification of the language.

Use of the term "physician extender." We believe that there is need to explore other possible ways to clearly denote the concept of a primary health practitioner and we request that nurse practitioners, because of the nature of their license and professional education, be considered separately from "physician extender."

We request that the bill clearly state that physicians review all *medical* services furnished by "physician extenders." There are additional nursing services, such as patient education and monitoring and responding to patient's

illness and/or therapy, that do not require physician supervision.

We recommend the addition of a multidisciplined audit to utilization review. We recommend the addition of pediatric nurse practitioners to those prac-

titioners listed as certified by the American Nurses' Association.

We appreciate the opportunity to provide this testimony. The Council of Home Health Agencies and Community Health Services wishes to support and be of assistance to the Subcommittee in expanding services to meet the health care needs in rural communities.

THE SENATE OF WEST VIRGINIA, Charleston, W. Va., March 24, 1977.

Hon. DICK CLARK, U.S. Senate, Washington, D.C.

Dear Senator Clark: Pursuant to a resolution adopted by the West Virginia Senate Health Committee on March 21, 1977, I am communicating the committee's support of S. 708, the rural health clinic bill, which would allow payment from medicare funds for rural health clinic services.

West Virginia, as well as many other rural states, suffers from an increasing shortage of physicians in many of its rural areas. More than one half of the state's counties have one fourth as many physicians as other parts of

the country.

An approach, in this state, toward alleviating the physician shortage problem has been the development of rural satellite clinics as branches of urban medical centers. State initiative toward improving the delivery of health care in rural areas through these clinics and the expanded role of physician's assistants, nurse practitioners and other health care extenders has been hampered by the prohibition of reimbursement to clinics lacking full time physicians. We firmly believe in the physician extender concept which emphasizes preventive health care, thereby decreasing the need, in many instances, for care by physicians or in hospitals and increasing the level of the quality of care.

Our committee strongly favors the passage of S. 708 and appreciates your subcommittee's efforts in providing greater access to primary health services

for our people.

Sincerely yours,

ODELL H. HUFFMAN, Chairman.

SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT, Columbia, S.C., March 25, 1977.

Hon. DICK CLARK,

Chairman, Senate Rural Development Subcommittee, U.S. Senate, 404 Russell Bldg., Washington, D.C.

Dear Senator Clark: I would like to encourage passage of S. 708, the bill to amend Title XVIII of the Social Security Act to provide payment for physician assistants and nurses providing primary health care in rural health clinics. As South Carolina has one of the highest percentages of rural population in the nation, we have many individuals who find it extremely difficult or impossible to obtain continuing health care directly from physicians although they would be able to receive such care from "physician extenders." Many of these people live on the islands off the coast, in other remote rural areas without adequate transportation systems or physician care, in high poverty areas, and other areas recognized as having a high patient-doctor ratio which inhibits office visits.

As to methods of implementing S, 708, I would like to recommend that funds be made available to some central authority within each state to establish a certification process for rural health clinics and physician extenders who wish to request Medicare reimbursement. With these funds, trained personnel could be employed to help establish defensible unit costs and fee schedules in rural health clinics, procedures for referral, sound management practices, standards for medical supervision, etc. I believe such standards, certification, and monitoring by state personnel who are familiar with their operation would be necessary to assure quality services and prevent abuses. Once again, I wish to applaud the committee's efforts to bring about better

health care in rural areas to our nation and encourage support of S. 708.

Sincerely,

JOE S. DUSENBURY, Commissioner.

IOWA STATE DEPARTMENT OF HEALTH,
PUBLIC HEALTH NURSING SERVICE,
Maquoketa, Iowa, March 24, 1977.

Dear Senator Clark: I am pleased to see someone is finally thinking of the rural American. I am a Public Health Nurse in a rural county in Iowa. Our total population is 20,839 and we have a land mass of 644 square miles. Our urban population is 5,677 and our rural is 15,172. Fortunately, we have 14 physicians in the county; but unfortunately, 11 of them are in the county seat. The other 3 are located in two other of the larger towns in the country.

I feel your legislation would be beneficial if when you refer to "nurse practitioner", you are referring to the Registered Nurse. If this is not the reference, then your legislation will do nothing for us. Most new graduates of schools for registered nurses, are taught Adult Assessment Skills and these skills could be used in clinics in rural areas. As a Public Health Nurse, I can see us being assisted a great deal by such legislation. We would be able to set up rural health clinics, as we would have a way of defraying the cost through Medicare. Currently, it costs us \$55.51 for each half day clinic session. (Figure based on Time Study and Cost Analysis). Many of our citizens in the rural areas have been wanting rural health clinics. Some of our citizens must travel over 30 miles to the nearest physician and some are elderly with no means of transportation.

Reimbursement for the services provided could be handled in a similar manner as are reimbursements for hospital stay and Home Health Agencies costs—payment to the provider by the intermediary. The provider in this case being the physician's office that is sending out the registered nurse or physician's assistant, or the Agency (Public Health Nursing Agency) that is

certified to provide clinic services.

The requirements should be similarly written and fulfilled as those for a Home Health Agency. A clinic should be established with written policies and procedures. The method for providing the service should be clearly spelled out. There should be standing orders available from the: physician, if the extenders are provided through a physician's office; or from the County Medical Society, if the extenders are part of a Public Health Nursing Agency. The Physician should become involved with diagnosing a patient referred to him and also should be closely involved with the initial planning stages. Policies which clearly state normals and abnormals of tests provide method of providing services, methods of record keeping to be done, who is responsible, how referrals are made, etc., should be available before the clinic is in operation.

A certifying procedure should be followed—somewhat similar to that of a Home Health Agency. That is, someone who is very familiar with all the guidelines set up should visit each agency applying for certification, review the policies set up, review the record keeping system, review the education of the providers, and etc. In this manner, some quality assurances are made available. This certification should be done initially, then after 6 months of operation, and yearly thereafter. Annually, a time study and cost comparison should be done to estimate fees.

As a Public Health Nurse, I feel very strongly about us being included in legislation of this type. I do not feel it necessary for the extender to be

connected to a hospital, other than knowing where the nearest hospital is and perhaps utilizing the laboratory for extensive blood tests. I see no problems with the extender not coming directly from a physician's office, as long as the extender is working with the Medical Society and realizes the expecta-tions of their local physicians individually, as well as in a group. I do feel the extender should be a part of an organization—ex: State Department of Health connected—so there is uniformity in the happenings in the clinics and assistance available for the planning and development of the clinics. Having recently been to a meeting of our County Committee on Aging, it seems health care is among the priorities for those 60 years and over.

It is good to see that those on the Federal level are realizing that "Health care is a right" of all the citizens and not just a privilege for those who can afford it. It would be much easier for us working with the local government-County Supervisors-if they would be made aware of this as well. Their only concern and all they seem to understand are roads and county offices. (Even the money we bring in goes back into the General Fund.) It seems that the only method for this is Federal legislation and State legislation to provide each county with a Health Department by the State paying salaries and expenses and the County housing the office and providing office needs. Similar to what has happened with the Department of Social Services.

Thank you for this opportunity to be heard. I was pleased to see so many bright with Nurses ettending and testify a year Health Nurses ettending and testify a year Health Nurses.

Public Health Nurses attending and testify at your Hearings on Rural Development. Enclosed is a copy of our annual report.

Sincerely,

KIMBERLY DEPPE, RN, PHN, Jackson County Public Health Nurse.

NORTH CAROLINA HOSPITAL EDUCATION AND RESEARCH FOUNDATION, INC., THE PROGRAM ON ACCESS TO HEALTH CARE. Raleigh, N.C., March 25, 1977.

Re S. 708 Medicare Reimbursement to Rural Health Clinics.

Senator DICK CLARK,

Senate Rural Development Subcommittee, Washington, D.C.

DEAR SENATOR CLARK: Mr. James R. Felts, Jr. of The Duke Endowment, Charlotte, N.C., has suggested that we reply to your letter of March 7

inviting his comments on the above measure.

The Program on Access to Health Care, supported by The Duke Endowment, The Kate B. Reynolds Health Care Trust and The Z. Smith Reynolds Foundation, assists in developing projects to expand primary health services to rural and other underserved communities in North Carolina. The following comments are based upon our experience with several projects utilizing physician extender personnel and the advice of others who have been associated with rural health clinics of this nature.

1. There are twenty or more presently established or planned clinics in our state that would likely benefit from this amendment. In most instances these serve communities of higher than average concentration of the elderly, who are either reluctant to use the services because of the Medicare prohibition, or who by their inability to pay the full cost of services, contribute in many cases to substantial operating deficits. We believe that if this one impediment were eliminated most of the clinics served by nurse practitioners eventually would be self-supporting, and the extender concept expedited to areas with which this legislation is concerned.

Reimbursement under Medicare should be determined on the same basis as for Medicaid; that is, cost, using the Medicare formula as for hospitals and other clinics. The fact that extender clinics in North Carolina are re-imbursed \$12 per visit for Medicaid patients and nothing at all for Medicare patients-both supported by federally mandated programs-is obviously in-

3. It would appear that paragraphs (B), (C), (D), (E), (F) and (G) of the bill adequately define eligibility criteria.

4. The certification process for providers whose services would be reimbursed under this legislation, as established by North Carolina statutes for Physician's Assistants and Family Nurse Practitioners, has proven to be satisfactory. Copies of the State's applicable statutes and regulatory procedures are enclosed.

5. Reimbursement should be based on *quality* of services rather than on the geographical area in which services are rendered. We think it would do an injustice to underserved neighborhoods in urban areas by confining the provisions of the bill exclusively to rural communities. Hopefully, the definitions

of rurality will be deleted.

6. With respect to (3 of paragraph (H), page 3 of your enclosure, it does not necessarily serve the public's interest to require certification of practitioners by professional membership societies. For example, the provision that "Adult-Family Nurse Practitioners" be certified by the American Nursing Association might well be deleted from the legislation.

Sincerely,

WILLIAM F. HENDERSON,

Director.

STATEMENT OF THOMAS G. DORRITY, M.D., CHAIRMAN, LEGISLATIVE COMMITTEE, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

The Association of American Physicians and Surgeons, which has been invited to comment on S. 708, is a 34-year-old organization of physicians who are engaged exclusively in the practice of private medicine. AAPS members in all 50 states are doctors of medicine whose primary occupation is taking care of patients. AAPS, therefore, is particularly qualified to comment on S. 708, a bill which is designed to allow so-called physician extenders (or assistants), nurse practitioners, nurse clinicians "or other trained practitioner" (whoever that may be) to practice medicine without an M.D. degree, without a license and without effective, on-the-spot supervision of a licensed physician.

We believe enactment of S. 708 or its counterpart in the House, H.R. 2504, would establish a dangerous, ill-advised and unnecessary precedent. With minimal benefit to patients, its potential for harm would be incalculable. S. 708 would create a new classification of medical practitioner, empowered by federal law to practice medicine without the extensive and enacting education and training required of licensed physicians. This legislation would define a "physician extender" as one of several individuals "who (are) legally authorized to provide any physician services, as defined in section 1861 (q)" of the Medicare law. Section 1861 (q) defines physicians' services as "professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls . . ."

The concept of physician extender—as its name implies—is an extension of the physician, an individual who is qualified to perform services for the physician which do not require medical licensure, but which are nonetheless done under close supervision of a physician. But S. 708 would shatter that concept by authorizing physician extenders to undertake medical procedures with no more than occasional supervision by a physician—and after the fact at that. They would be independent of physicians. They would be employed by a clinic run by nonphysicians and would thus be more responsible to the employer than the patient.

The risk to these patients is obvious.

The ostensible purpose of this legislation, according to its sponsors, is to allow HEW to pay for the care of Medicare patients treated by physician extenders in rural clinics when no physician is present to supervise the supervise property to supe

extenders in rural clinics when no physician is present to supervise.

The evidence to justify this kind of legislation is not at all persuasive. Senator Dick Clark of Iowa, the primary sponsor of S. 708, contended in his explanation of the bill published in the Congressional Record that "thousands of communities" in the nation rely on services provided by physician extenders in rural health clinics because "the populations of these areas are insufficient to financially support a full-time physician . . ." The statement does not square with his assertion that "rural" is so broadly defined that "only communities of 50,000 or more inhabitants and their closely settled 'fringes' would be excluded because they would be considered urban."

It may come as a shock to the inhabitants of such Iowa cities as Ames, Burlington, Clinton, Ft. Dodge, Marshalltown and Mason City that their cities would "in size and by nature" qualify as rural, that they, the citizens, are unable to financially support a full-time physician, or that they are what the bureaucrats are pleased to call "medically underserved."

Equally unbelievable is Senator Clark's claim that in some "remote areas" of the United States, "one extender is responsible for the health of hundreds or even thousands of people." Where are these areas of America so remote but so populous that one, only one, unlicensed layman uneducated in medicine

serves the medical needs of thousands of individuals?

The manner in which this legislation is being promoted unfortunately suggests that there is some motive besides authorizing payment of Medicare bills

in so-called rural health clinics.

Senator Clark, for example, read into the Congressional Record a letter from a resident of Albert City, Iowa, who is promoting the organization of such a clinic, Senator Clark cites Albert City-evidently on the strength of this letter—as "typical of communities across the nation that are searching for some solution to their lack of health services." The letter contends that some physicians in Storm Lake want to establish a "satellite clinic" in Albert City and let a physician assistant, only occasionally checked by a physician, provide medical care for residents of that city. The writer of the letter complained that the project can't succeed unless HEW is allowed to pay for services to Medicare patients performed by a physician assistant without onthe-spot physician supervision.

Failure of the project, said the clinic promoter who wrote the letter, would

leave Albert City "without any medical services whatsoever."

Sounds dreadful, doesn't it? It really is not. If Albert City is typical of similar American communities, it is dramatic testimony AGAINST delivering thousands or millions of our citizens into the hands of physician assistants

or nurses as the sole source of their primary medical care. "Typical" Albert City is NOT without medical services, as claimed by the writer of the letter, who also implied that a hospital in Storm Lake 35 miles away was the only one serving Albert City. That's not exactly the way it is in Albert City. True, Albert City does not have a resident licensed doctor of medicine. But there is a doctor and an osteopath in Laurens seven miles away who take care of Albert City patients. Furthermore, there are four physicians in Pocahontas about 15 miles away.

The Storm Lake hospital is not the only hospital serving Albert City. There is one closer—at Pocahontas. And the hospital at Pocahontas, approved for Medicare, does serve Albert City patients, including Medicare patients. According to maps, incidentally, Storm Lake is not 35 miles from Albert City, but less than 25. That's not all. Some 35 miles straight west is Cherokee. which has more than 30 physicians and two hospitals, a 408-bed Mental Health Institute and a 134-bed general hospital, the Sioux Valley Memorial Hospital.

S, 708 is patently not intended to alleviate an alleged problem of reimbursing elderly patients for Medicare Part B services in remote, rural areas of the United States where physicians are unavailable to a significant portion of Medicare recipients. It is clearly intended to promote the development of Russian-style feldscher medicine in populous areas of this country. Senator Clark stated in the Congresisonal Record that this S. 708 scheme would affect all communities in the nation up to 50,000 population. By this ridiculously strained and stretched definition of "rural" S. 708 would launch this kind of second-rate, dangerous medical care in areas in which, said Senator Clark, 35 million Americans live—more than 16% of the entire U.S. population.

This is the kind of cut-rate medical care that is visited upon millions and millions of unfortunate citizens of Russia. Men and women, primarily women. with no more than two years schooling in medicine are dispatched throughout Russia to tend the medical needs of most of the population. These practitioners are called feldschers and, as would the extenders in S. 708, they are

subject only to periodic review by a physician.

This can't really be the kind of medical system that anyone would want for Americans. Is it the kind of medicine you want for yourself or for your elderly mother or father? We believe the answer members of the Senate Rural Development Subcommittee will give to that question is a clear and emphatic "NO!"

The members of the Association of American Physicians and Surgeons profoundly hope that will be your answer. You cannot believe that so many citizens of this nation are so deprived of needed medical care that such a drastic proposal as S. 708 is necessary. You cannot believe that Americans should be exposed to such a system of second-rate medical care. Untrained and unsupervised physician assistants and nurses, uneducated in medicine and unqualified to make the split-second medical decisions that can mean the differences between living and dying, should not be allowed to practice medicine in enlightened America.

We urge you to reject S. 708, not only as unnecessary but dangerous.

VERMONT ECUMENICAL COUNCIL AND BIBLE SOCIETY, Burlington, Vt., March 23, 1977.

Senator Patrick Leahy, U.S. Senate,

Senate Office Bldg., Washington, D.C.

Dear Pat: S-708, to provide Medicare coverage for health services provided by nurse practitioners and physician extenders in rural health centers, is a vitally necessary bill to cover a serious lack in current Medicare policy.

There is no question small communities unable to secure the services of a full-time physician have, as in Vermont, discovered the invaluable service

provided by rural health centers.

In order to insure that such centers do not abuse their participation in Medicare, it might be well to legislate that they be nonprofit organizations controlled by a local consumer-dominated board. I can see the outrider rural health centers could be lucrative extensions of private practice or profitable adjuncts to faltering hospitals. There certainly is a value in coordinated health care and both hospital and private practices are at present necessary, but local people need to plan and own their own health care delivery systems.

I also believe that as part of this legislation consideration needs to be given to a similar provision for home health care. There are a growing number of elderly people in this country unable to get to a rural health center for whom home health services are imperative for their continued independence.

Many Medicare recipients are only one step away from Medicaid. Medicare payments for home health care that keep the elderly people at home and independent can save the government large sums of money that would otherwise be paid to nursing homes.

Faithfully,

HOWARD STEARNS, Executive Minister.

STATEMENT OF PLANNED PARENTHOOD ASSOCIATION OF VERMONT, INC.

A major goal of Planned Parenthood of Vermont as defined by its Board of Directors in 1976 is to increase the availability of family planning services to low-income, rural women. In an effort to reach this goal, Planned Parenthood of Vermont has increased the utilization of both nurse practitioners and physician's assistants as providers of primary routine gynecologic and family planning care. Prior to the full utilization of nurse practitioners and physician's assistants within Planned Parenthood of Vermont the major provision of family planning services was rendered by physicians. Because of the documented limited availability of physicians, the limited time commitments of those physicians available and the high cost of utilizing physicians, Planned Parenthood of Vermont was forced to make modifications in its family planning services available to Vermont's rural population. These modifications limited the availability of service sites. It required the scheduling of patients to maximize utilization of physician time which perpetuated the crisis-orientation of medical care. With many patients to attend and with limited time, it is a rare physician who can focus on primary health education which can, in the long run, reduce the need for medical care.

¹ Family Planning Services in Vermont: Focus for State Initiative, Alan Guttmacher Institute, Page 7.

With the introduction of nurse practitioners and physician's assistants providing routine gynecologic and family planning care, the delivery of health services to rural women in the state of Vermont can be improved and increased. The availability of service sites staffed by nurse practitioners and physician's assistants can increase the accessibility of family planning services in this state. The utilization of less costly medical personnel will allow a woman more time to spend with the medical provider so that her needs are fully met. The nurse practitioner or physician's assistant can address himself or herself to the needs of: (1) essentially well women who may need preventive health counseling to maintain her health status; and (2) the worried well woman who needs time to voice her concerns and have her questions answered. The nurse practitioner and physician's assistant further serve to screen the woman who is not well and to refer her for appropriate medical care.

It should be kept in mind that utilizing a nurse practitioner and/or physician's assistant to provide primary health care involves creating a *system* of medical care in which the nurse practitioner or physician's assistant plays an integral part. It is the *system* of care that should be evaluated to determine eligibility for Medicare/Medicaid reimbursement and not the actual person who provides the care.

Components of this system of care should include:

(1) Properly trained and educated nurse practitioners and physician's assistants. Although it may appear that certification of physician's assistants through the National Commission on Certification of Physician's Assistants is a desirable means of certification because of its uniformity and standards, it should be kept in mind that such criteria for certification will jeopardize utilization of highly skilled, highly qualified specialty physician's assistants who have met the generalized standards of registration for physician's assistants in Vermont. Until such time as the Commission is able to respond to the certification needs of all physicians assistants, such criteria for certification creates just as many problems as it solves in the utilization of physician's assistants. For your further information I have enclosed a copy of an alternative proposal for registration of physician's assistants prepared by the staff of the Vermont Women's Health Center, in Burlington.

(2) A supervisory physician who is responsible for the actions of the nurse practitioner or physician's assistant and who has provided clearly defined standing orders and medication orders or a suitable protocol medical services

provided by nurse practitioner and/or physician's assistants.

(3) Immediate emergency back-up system.(4) A clearly defined system of referral.(5) A system of on-going medical audit.

It is the woman who relies on Medicare/Medicaid to cover her medical expenses and who in most instances has limited income and limited transportation who could most benefit from such a system of care of which the nurse practitioner/physician's assistant is in the forefront. It is this same woman who cannot avail herself of the medical service provided by the rural health clinic that utilizes nurse practitioners and physician's assistants. The health care of this women is compromised. She is left with the option of seeking care from a physician to whom she has limited access or to go without the health care to which she is entitled. Such a dilemma is created by the Medicare/Medicaid policy that does not allow for reimbursement for health services provided by nurse practitioners and physician's assistants.

For comparative purposes it is of value to note that the Vermont Title XX Comprehensive Service Program Plan does not create such an obstacle to

the accessibility of health for rural women.

In 1976, the Alan Guttmacher Institute estimated that 23,400 women in Vermont, ages 15 through 44, were at the risk of unwanted pregnancy and, therefore, in need of family planning services. Approximately 5,800 of those women were estimated to be eligible for Medicaid, yet in the calendar year 1976, Planned Parenthood of Vermont only served 737 Medicaid patients (which represents 9.5% of the total number of patients seen), partly due to the restrictive nature of the Medicaid regulations. The need for family plan-

² Family Planning Services in Vermont: Focus for State Initiative, Alan Guttmacher Institute, Page 9.

ning services has been demonstrated, and the limited availability of physicians to provide these services to rural Vermont women has also been demonstrated. Creating unnecessary obstacles to answering the family planning needs of Vermont's rural population by allowing the poor Medicare/Medicaid policy of reimbursement to continue only serves to increase the need and to confirm the imbalance and maldistritution of health care servics.

R. JAMES LEFEVRE,

Executive Director, Planned Parenthood of Vermont.

JUDITH WECHSLER, P.A.,

Practitioner Manager, Barre Center.

STATEMENT OF PHYSICIAN'S ASSISTANTS IN VERMONT

A number of highly trained non-physicians and non-nurses are operating in responsible health care positions throughout Vermont. The need for and the usefulness of this group is increasing. In Vermont most of our physicians are centered around the university hospital in Burlington while a shortage of physicians exists in many rural areas of the state. Even near medical centers, care can be difficult to obtain—often highly skilled physicians spend much time teaching or doing research and only a fraction of their time in direct patient care. As the cost of educating physicians and the expense of receiving their service spirals upward, health care becomes prohibitively expensive to those without insurance and often a burden to those directly and indirectly responsible for paying insurance costs.

indirectly responsible for paying insurance costs.

Increasing the number of providers directly involved in patient care and broadening their distribution makes care more available. Utilizing well trained and less expensive physician's assistants to perform routine and specialized tasks decreases the costs. Physicians are freer to spend their time dealing with the complex and challenging problems that fully utilize their skills. The tasks that are often neglected as low priority (patient education, counseling and health maintenance screening) are done inexpensively. Medicine can move away from crises oriented care to preventative care. By assuming these roles, physician's assistants help to increase the thoroughness and availability of

care while containing the costs.

Vermont has not developed a university program to train physician's assistants. Because of UVM's large commitment to the medical and nursing schools, it is unlikely to be able to create and support one. Vermonters must either leave the state to be trained or find a local physician who is willing to train and utilize a Physician's Assistant. The cost of an out-of-state program is more than tuition; it means leaving employment, family and community. For most Vermonters, it is beyond reach. The value of local Physician's Assistants is multifaceted. Their training can be as complete as a university program, and certainly as practical. The Physician's Assistant trains in the community and she/he is a member of, and is likely to continue to work in. Training is geared to the specific needs of a population and responsive to changes it it. The Physician's Assistant gains valuable knowledge of, and becomes a member of the health care community. She/he continues to be a productive part of the work force throughout training.

Apprenticeship is an honored Vermont tradition. It supports the concept of Vermonters as self-reliant and independent. Even in the health field, informally trained aides have provided much needed quality care. However, as the state grows, as the delivery of health care becomes more complex, and as providers become more directly accountable for their actions, it is necessary to create standards for evaluation and registration of this responsible and skilled group,

physician's assistant.

Proposal for Registration of Physician's Assistants in Vermont

In order to insure the delivery of high quality health care, both University-trained and physician-trained Physician's Assistants should be evaluated and registered by the Board of Medical Examiners. The following outline presents an evaluative procedure for whatever committee they choose.

I. REGISTRATION

A. Registration of physician-trained Physician's Assistants

1. Approval of the individual's training program:

(a) Definition of skills and tasks necessary to meet the needs of a

specific population and practice (job description).
(b) Description of method of training and level of competency required. (c) Description of method by which the practice audits performance

and controls the quality of care.

2. Interview and on-site visit to assess each individual at the end of the training period.

3. Approval of a plan for continuing education and training.

4. Registration of Physician's Assistants to perform tasks outlined in the supervising physicians standing orders.

B. Registration of University-trained Physician's Assistants

1. Review and approval of each university program.

2. Approval of employing program:

(a) Definition of skills and task necessary to meet the needs of a specific population and practice (job description).

(b) Description of the method by which the practice audits performance

and controls the quality of care.

3. Approval of a plan for continuing education and training.

4. Registration of Physician's Assistant to perform tasks outlined in the supervising physician's standing orders.

II. REREGISTRATION

A. Physician's Assistants continuing in the same practice should be reregistered every three (3) years by

1. Re-evaluation of skills by an on-site visit.

2. Re-evaluation of the audit and feed-back loop of each practice. 3. Submission of a plan for continuing education and training.

4. Submission of a job description revised to include any changes in protocol and responsibilities.

B. Physician's Assistants changing to a different practice

1. Approval of the program:

(a) Definition of job description.

(b) Description of training method when different skills are required.

(c) Description of system of audit and quality control.

2. Registration of Physician's Assistant to perform tasks outlined in the supervising physician's standing orders.

SUGGESTIONS FOR IMPLEMENTATION

1. The Board could hire interested physicians to evaluate programs and individuals.

2. Programs that concentrate in specialized areas of health care, such as pediatrics or gyn, could be evaluated by MD's in those fields.

3. Evaluation of programs and certification of individuals could be done at

only two specific times each year.

4. Costs could be absorbed by an increase in registration fees.

STATEMENT OF DONALD W. WHITEHEAD, FEDERAL COCHAIRMAN, APPALACHIAN REGIONAL COMMISSION

Mr. Chairman, my name is Donald W. Whitehead. I am the Federal Cochairman of the Appalachian Regional Commission. One of the unique characteristice of the Appalachian Regional Commission is that its programs are developed and administered in partnership with the Governors of the thirteen Appalachian States. The member Governors select one of their number to serve as States' Cochairman. Currently, Governor Marvin Mandel of Maryland is the States' Cochairman. The member states pay half the costs for administering this program and have an equal role in determining program goals and priorities.

The population of the Region served by the Commission is largely non-metropolitan; 45 percent of the Region's 19 million people live in open country or towns of less than 1,000 persons. Consequently, we tend to be concerned about issues that affect rural people.

Since its inception in 1965, the Commission has tried to develop programs that would improve rural health status without draining the rural purse. Primary health care clinics staffed by physician extenders are one of our success-

ful solutions to that problem.

Concerned about the plight of our clinics, the Commission, at a meeting in Annapolis, Maryland, March 21, adopted a resolution calling upon President Carter to join us in a request to Congress to act quickly on legislation to permit Medicare reimbursement for the services of the physician extenders in these clinics. Specifically, that resolution states:

Whereas, the overall Commission program of developing primary health care services in underserved rural areas is seriously jeopardized by the failure of

Medicare to reimburse physician extenders, and

Whereas, even though the total question of reimbursement is complex and affects other professions, the settlement of the question of reimbursement for physician extenders should not be postponed until all the complex issues on all related matters have been totally resolved, and

Whereas, the Carter Administration has endorsed legislation now pending before the Congress, which, when approved, will overcome existing limitations

under Title XVIII of the Social Security Act, and

Whereas, the people served by these clinics have no alternative accessible

sources of health care: Now, therefore, be it

Resolved, That the Appalachian Regional Commission hereby expresses its appreciation to President Carter for his support of pending legislation, and Hereby requests priority attention to the Administration's efforts and prompt

Hereby requests priority attention to the Administration's efforts and prompt passage of appropriate Legislation.

passage of appropriate Legislation.

Last June, the Commission passed another resolution that outlines the conditions under which the members endorse reimbursement for physician extenders. Specifically, these are:

(a) The physician extender is functioning in an organized health care sys-

tem;

(b) The physician extender is providing medical services according to written standing orders agreed upon by a duly licensed physician whether or not services are performed in the office of, or at a place at which such physician is physically present;

(c) The physician participating in the written orders assumes full legal and

ethical responsibility as to the necessity, propriety and quality thereof;

(d) The reimbursement be provided at a rate commensurate with the services provided, rather than the provider of services; and

(e) The reimbursement be made to the clinic or sponsoring organization. The Commission prefers to recognize as physician extenders, persons who have met criteria set by a state or by the Secretary of the Department of Health, Education and Welfare, such as those designed for maintaining current certification as a Physician Assistant by the National Commission on Certification of Physician Assistants, and who are licensed or otherwise recognized by a State as qualified to provide primary health care services in the State in which such services are rendered.

Mr. Chairman, S. 708 addresses that resolution in every respect.

By now, you and the members of your committee have heard of the dilemma facing our clinics. As the months move on, this is reaching crisis proportions.

If I may take a moment to provide some background:

Part of the Commission's program, authorized by the Appalachian Regional Development Act of 1965, As Amended, is "... to demonstrate the value of adequate health facilities and services to the economic development of the region." A major part of this demonstration activity has established over 200 primary health care clinics, half of them in isolated rural areas that have great difficulty obtaining the services of a physician. These clinics must rely on the services of physician extenders.

The statute establishes a limit of five years (60 months) for assistance to all operating projects. At the end of this period, the clinic must find its support from non-federal sources or restrict its services to people who can pay the total cost of the service. Unfortunately, many eligible people are required to

pay because the cost of the service cannot be reimbursed under Title XVIII and Title XIX of the Social Security Act—Medicare and Medicaid. Currently, Title XVIII prohibits reimbursement for services provided by a physician extender unless the service is provided under immediate physician supervision.

Title XIX in some states has similar prohibitions.

On May 1, 1977, five (5) of our most remote rural clinics will reach the end of their eligible period of support. The Medicare share of costs in each of these is approximately \$11,000 per year. This does not seem like much, but these clinics have no means to absorb such deficits. Nonetheless, this shortfall may force them to close their doors — denying care to almost 11,000 people, who are both Medicare and non-Medicare beneficiaries.

These five clinics are not isolated examples. The Frontier Nursing Service, a network of seven nurse practitioner clinics in Southeastern Kentucky, face a deficit of some \$140,000 this year, attributable to care for Medicare patients whose services were not reimbursable. FNS has already closed three of its clinics because of the combined financial strain of Medicare and Medicaid re-

fusal to pay for the medical services provided by nurse practitioners.

In June, Farmington, Mansfield and Elkland clinics will face the same dilemma; Briceville, Byrdstown and others will join them as the summer pro-

gresses. More than 40 clinics will be in trouble by Fall.

If these clinics fail, we will have destroyed the growth of an alternative to expensive hospitalization. At their current costs, these clinics provide visits for chronic care to Medicare patients at one-sixth (1/6) the price of a single day in the average hospital. The study recently completed for the ARC by the Mitre Corporation 3 suggests that these clinics do, in fact, contribute to reduced

hospitalization-10 to 30 percent over paired control communities.

The March 21 Commission resolution also ask for interim grant aid for these clinics to protect them while we resolve the points in this legislation. Already, we are too late to save these pioneers: "Furthermore, until such time as the Congress can complete its deliberation on the amendments to Title XVIII of the Social Security Act, the Appalachian Regional Commission requests the President to waive Federal regulations that bar those Commission-sponsored rural primary health care clinics from eligibility under the Department of Health, Education and Welfare's program for Health Underserved Rural Areas."

The recent health manpower legislation notwithstanding, physicians are not moving to rural areas. In some rural parts of Appalachia, particularly the rural South, physicians are still leaving.4 Yet, with grant support, physician extenders have been willing to settle into the same areas vacated by the physicians. The current estimated 500 to 800 clinics nationwide 5 represent only a partial answer. They serve only one-sixth (1/6) of the nation's rural medically underserved areas. Without passage of S. 708, the remaining 83 per-

cent of these areas will continue to be without service.

Mr. Chairman, your leadership and that of your co-sponsors is to be commended. Your bill clearly represents a fiscally responsible method for continued assistance for rural primary health care clinics. To further its objectives, I would like to stress our support of several of the bill's points.

1. Although the wording in Section (b) (aa) appears to need amendment to include the term, "physicians services," in order to make their inclusion clear, we applaud your decision to include reimbursement for services of physician extenders when they are provided in clinics which are also staffed by physicians. This is a frequent occurrence in Appalachian clinics.

2. You are recommending reimbursement based on costs reasonably related to the provision of services. Again, welcoming your decision to recommend costbased reimbursement, we would hope that you would ask that the Secretary apply tests of reasonableness to the costs, rather than permit the costs to escalate without control, as has occurred in other Medicare cost-reimbursement programs. Our clinics are presently operating on moderate standards that keep their costs low and make them accessible to their clientele. If the Medicare regulations were to discourage this, we would later be accused of contributing to unnecessary inflation in health care costs.

3. S. 708 provides reimbursement to the clinics directly. This will greatly

facilitate management and billing.

4. S. 708 requires that the clinics have a means for utilization review. Some have expressed concern to us that this is a term of art, requiring sophisticated staffing. We suggest that the same intent could be preserved were the bill to

require "quality control."

5. We notice that you have not added a grandfather clause to insure that clinics can continue to receive reimbursement if their area is no longer designated medically underserved. This oversight appears to mark as second-class services good only for emergencies. The Commission wholeheartedly supports the quality of these clinics as permanent services.

Thank you, Mr. Chairman, for the opportunity to present testimony on this

important piece of legislation.

Enclosures.

FOOTNOTES

1. Section 202 of the Appalachian Regional Development Act of 1965, as Amended.

2. SSA/OPPP/ORS Health Insurance Statistics Bulletin No. HI-76, March

4, 1977, DHEW, Washington, D.C.

3. Carol Anderson, Ed Nedham, Donald Vicary, "Effect of Primary Health Care Provided by Physician Extenders on Total Community Health Costs," February 1977 (ARC, unpublished).

4. Jerome Pickard, ARC data file, January 1977.

5. Unpublished SSA/DHEW actuarial estimate, February 1977.

APPALACHIAN REGIONAL COMMISSION RESOLUTION NUMBER 407

A Resolution Concerning Medicare Reimbursement of Physician Extenders. Whereas, the 1972 Amendments to the Social Security Act, P.L. 92-603 directed the Secretary of the Department of Health, Education and Welfare to examine the quality, cost and range of health care that can be appropriately delivered by non-physician providers, and to determine the constraints that should be imposed in order to permit Medicare reimbursement for services provided by such persons; and

Whereas, in Senate Report 94–278 accompanying the 1975 Amendments to the Appalachian Regional Development Act, the Public Works Committee of the Senate noted, as a serious problem, that present Medicare regulations do not recognize or permit reimbursement for primary health care services provided by a nurse practitioner or other physician extender, unless a physician is physically present; and urged consideration of this problem by the Senate Fi-

nance Committee and the appropriate Committee of the House; and

Whereas, the Appalachian Regional Commission, together with the Tennessee State Health Department, the North Carolina Office of Rural Health Services, the Kentucky Health Resources Development Institute, the Frontier Nursing Service, the West Virginia Regional Medical Programs, the Tennessee Valley Authority, the United Mine Workers Health and Retirement Funds, the Southern Labor Union, and the Vanderbilt Center for Health Services, among others, have found by trial and careful testing, that physician extenders do provide appropriate primary health care, especially to persons in medically underserved areas, who otherwise would have limited ability to exercise their entitlement to Medicare services; and

Whereas, physician extenders are physician assistants, nurse practitioners, nurse clinicians, or other trained practitioners, who have successfully completed a program of study approved by the National Board of Medical Examiners, or who are licensed or otherwise recognized by a State as qualified to provide primary health care services in the State in which such services are

rendered: and

Whereas, the Commission and other sponsoring agencies above mentioned have also found the services provided by these physician extenders, who function in organized systems of care (whether or not performing in the office of, or at a place at which a physician is physically present), to be of commendable quality; and

Whereas, the above-mentioned agencies have also found that services provided in this manner help to prevent escalation of health care costs for Medi-

care beneficiaries; and

Whereas, Section 102(a)(3) of the Appalachian Regional Development Act authorizes the Commission to review Federal, State and local public and private programs, and where appropriate, recommend modifications to increase their effectiveness in the Region: Now, therefore, be it

Resolved, That the Appalachian Regional Commission recommends that Title XVII of the Social Security Act, Part B Supplemental Medical Insurance (42)

USC 1305), and all such other medical entitlement programs be amended to permit:

(1) Reimbursement for primary health care services provided by physician

extenders, as defined above, when the following safeguards are met:

(a) The physician extender is functioning in an organized system of care;

(b) The physician extender is acting under written standing orders agreed upon by a duly licensed physician (whether or not such services are performed in the office of, or at a place at which such physician is physically present at the time of the specific service); and

(c) The physician providing the written orders assumes full legal and ethical

responsibility as to the necessity; propriety and quality thereof;

(2) Such reimbursement be provided at a rate commensurate with the service provided rather than according to the provider of care; and

(3) Such reimbursement be made to the clinic or sponsoring organization.

Approved: June 22, 1976.

MILTON J. SHARP,

Governor of Pennsylvania, States Cochairman.

Donald W. Whitehead, Federal Cochairman.

APPALACHIAN REGIONAL COMMISSION PROPOSED RESOLUTION

A Resolution Concerning the Need for Immediate Action To Permit Reim-

bursement of Physician Extenders.

Whereas, the Appalachian Regional Commission has demonstrated that primary health care clinics staffed by nurse practitioners, physician assistants and other physician extenders specially trained for primary health care, are extremely effective in making quality health care accessible to people in more than 100 communities that would otherwise have no health care, and keep costs of health care within reasonable reach of the people, and

Whereas, building on this achievement, several member States (Kentucky, Tennessee, North Carolina, Maryland and New York) have developed special

State-level programs to expand the use of physician extenders, and

Whereas, these clinics cannot be self-sufficient unless their services are reimbursed by Medicare, Medicaid and private insurance programs, and

Whereas, current Federal law restricts such payments, and

Whereas, the Commission, almost a year ago, in June 1976, unanimously approved Resolution 407, which asked that the Social Security Act be changed to accommodate reimbursement for services provided by physician extenders working in primary health care clinics, and

Whereas, legislation that would correct this problem has been introduced in both the United States House of Representatives and Senate, but not acted

upon, and

Whereas, the overall Commission program of developing primary health care services in underserved rural areas is seriously jeopardized by the failure

of Medicare to reimburse physician extenders, and

Whereas, even though the total question of reimbursement is complex and affects other professions, the settlement of the question of reimbursement for physician extenders should not be postponed until all of the complex issues on all related matters, have been totally resolved and

Whereas, the Carter Administration has endorsed legislation now pending before the Congress, which, when approved, will overcome existing limitations

under Title XVIII of the Social Security Act, and

Whereas, the people served by these clinics have no alternative accessible sources of health care: Now, therefore, be it

Resolved, That the Appalachian Regional Commission hereby expresses its appreciation to President Carter for his support of pending legislation, and

Hereby requests priority attention to the Administration's efforts to obtain

prompt passage of appropriate Legislation.

Furthermore, until such time as the Congress can complete its deliberation on the amendments to Title XVIII of the Social Security Act, the Appalachian Regional Commission requests the President to waive Federal regulations that bar those Commission-sponsored rural primary health care clinics from eligibility under the Department of Health, Education and Welfare's program for Health Underserved Rural Areas.

STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION

The American Optometric Association, representing some 20,000 optometricts, applauds the Congress in its efforts to deliver quality primary care services to

Medicare beneficiaries.

The Congress' efforts are exemplified by introduction of legislation for reimbursement of Medicare-covered services when provided by physician extenders. The intent of this legislation is to allow primary diagnosis of injury and illness by physician extenders in rural health care clinics. This intent is well founded since physician services are lacking in many rural communities.

This Association supports the concept of serving the public's health care needs by balancing and utilizing the services provided by all health pro-

fessionals.

Optometry, as the primary entry point in the eye care delivery system, recognizes the important role of delivering primary care services as a preventive health measure. With health costs rising rapidly, preventive health is extremely important, both in costs-savings and maintaining the health of all Americans.

While this association supports the extension of Medicare reimbursement for services provided by physician extenders, it is imperative that those services for which reimbursement is made be only within the scope of services that physician extenders are able to render according to the laws of the respective states in which they provide these services. To protect the best interest and health of the patient, physician extenders cannot provide services that they are not educated nor licensed to provide.

Optometrists provide a vital role in delivering primary vision care to rural Medicare beneficiaries and should be considered for reimbursement for those

services that they are licensed to perform.

Proper vision care is one of the overlooked needs of the elderly American. Without proper sight, one has difficulty in performing ordinary daily tasks. Optometrists have been providing vision care in rural communities for years for those populations. Yet, Medicare beneficiaries in rural areas are unable to go to their optometrist for vision care because, with the exception of filling aphakic prescriptions, the optometris is not reimbursed for his examination under Medicare. This results in the elderly patient sometimes having to travel a great distance to obtain a vision examination or not receiving one at all, both undue hardships on an already burdened population.

The early diagnosis of health problems has long been one of the features of optometric vision examinations. Many diseases such as diabetes, arteriosclerosis and hypertension are detected through regular and periodic optometric exami-

nations.

By recognizing the role each health care professional plays in the delivery of health care to the nation's population, true quality health care can be delivered at reasonable costs to benefit the public's interest.

STATEMENT OF THE ASSOCIATION OF REHABILITATION FACILITIES

Mr. Chairman, the Association of Rehabilitation Facilities appreciates the opportunity to testify on a bill, \$708, the Rural Health Clinic Bill, which we consider of vital importance if this nation is to achieve any degree of equity in delivery of health services throughout the country. I am T. P. Hipkens, Director of the Association, and this bill is personally of interest to me since I previously held the position of President of Appalachian Regional Hospitals. A number of years ago, A.R.H. established several family health service clinics directed toward the same goals as \$708.

The Association of Rehabilitation Facilities represents over 1.000 rehabilitation centers and facilities of varying characteristics throughout the nation. The Rural Health Clinic Bill will have little or no impact on the reimbursement pattern for services provided by these facilities. However, many patients in rehabilitation facilities today suffering from the residuals of disease and injury would not be there if intervention had occurred earlier in the course of their condition. This is

particularly true in the case of chronic disease in children.

To illustrate this point let me draw upon some statistics from the Hazard Family Health Services Clinic in Hazard, Kentucky. Among the objectives of the Clinic are: "To stress delivery of health care through satellite clinics; To use the family health worker for well child care and home visitation, and; To stress child development." This clinic through utilization of family health workers and satellite clinics makes 70,000 patient contacts yearly in six counties. A "family health worker" or "pediatric nurse associate" is a Registered Nurse who has had exten-

sive pediatric experience and post graduate training in child care.

The motivating force behind the clinic was a 1970 study by the state Human Resources Coordinating Commission which demonstrated that 50 percent of the children reaching school age in 16 southeastern Kentucky counties had received no immunizations and had not had a physical exam since birth. The infant mortality rate varied from 22 to 30 per 1,000 and 37 percent of the children had iron deficiencies. In the current infant care out-reach program, a staff of 15 currently makes about 880 home visits monthly. No physicians are included in this group although they are available for consultation and referral. Other services include nutrition counseling for juvenile diabetics, women's clinic, obstetrical-gynecological clinic, prenatal services, and others.

Comparative studies with a group of children not enrolled in the HFHS indicate that *those enrolled* are healthier and their medical care costs were \$88.00 less per year per child. Results indicated a reduction of 40 percent in infant diarrhea

and anemia.

I recognize that this particular part of the testimony does not relate to the payment mechanism under consideration since S708 relates to Medicare. However, it is such a graphic illustration that the delivery system under question can be

highly effective that it is worthy of consideration.

In specific reference to S708, I would urge that the reimbursement procedure not be tied to a fee for service model which would lend itself to the establishment of satellite office practice by private physicians, rather that rural clinics be corporations formed by the community with representative boards of directors including consumers. Reimbursement should then be cost related on a salary equivalence basis and made directly to the corporation.

The corporation should have formal agreements with at least one acute care general hospital and immediate 24 hour phone or radio contact with the emergency service of the hospital. Included in the written agreements should be provisions for utilization review, referral, establishment of treatment plans and

periodic review of treatment procedures.

The State health agency should certify the agreements as meeting minimal standards in order to qualify the rural health clinic for reimbursement. The fiscal intermediary should review claims for compliance to the treatment plan and periodic physician review.

The Professional Standard Review Organization having responsibility for review of the acute care hospital should also review the workings of all rural health

clinics with whom the hospital has formal agreements.

STATEMENT OF DOROTHY CHAMPAGNE, DIRECTOR OF PRIMARY CARE TENNESSEE DEPARTMENT OF PUBLIC HEALTH

The State of Tennessee is deeply involved in the planning and implementation of primary care centers in rural areas. Mountainous terrain, economically depressed areas, and a significant maldistribution of medical services contribute to the necessity of state and federal involvement in the delivery of health care to rural citizens.

There are over fifty primary care centers throughout Tennessee, almost all of which are delivering health care through the services of a nurse clinician or nurse practitioners. Two clinics utilize physician assistants. At the present time these clinics, often in remote, isolated areas with no other available health care nearby, cannot be reimbursed by Medicare for the nurse's services, even though she performs the same diagnostic and treatment functions as does the physician.

In Tennessee this need has been given recognition: the Title XIX - Medicaid programs - reimburses for medical care given by nurse clinicians under physi-

cian supervision, even though that physician is not present at the time the service was rendered.

Obviously, nonreimbursement not only discriminates against the only services many people can obtain, but denies needed support to clinics struggling to exist in areas too poor to attract physicians. Many rural clinics are being supported by Appalachian Region Commission grants or Rural Health Initiative grants which have three or five year funding limits. Medicare reimbursement for nurse practitioners' services will help these clinics stay alive when grant funds are terminated. Medicare comprises at a minimum of 10% of all clinic visits.

REIMBURSEMENT METHOD

Reimbursement should be made to the clinic on a cost basis, regardless of the agent who delivers the care, to provide for the most economical method and to pay for clinic costs.

MINIMUM STANDARDS

In Tennessee, the Department of Public Health is presently involved in the setting of minimum standards for primary care clinics. These standards will address such issues as review of nurse practitioner performance and records by the physician preceptor; formal and informal linkages with other physician providers and other agencies for referral, consultation, and emergency care; the joint preparation of medical protocols by physician and nurse practitioner; utilization review, problem oriented records; and the dispensing of medications.

CERTIFICATION OF PROVIDERS

Nurse clinicians and nurse practitioners are already licensed R.N.'s. A process for certification as nurse clinician is available through the American Nurses Association, and many of our nurse providers have received or are in the process of receiving their certification. Many states have licensing or certification for physician assistants, though Tennessee does not. Legislation has been introduced to permit their licensure. At present, the R.N. license and graduation from an approved practitioner or clinician program is sufficient for practice in Tennessee.

Senate bill 708 is a good bill and well written. I would note in particular the reference in (aa) (2) (C) to the point preparation of medical orders by both

physician and nurse clinician.

I appreciate also your understanding of the ambiguousness of the term "physician extender". The educational and experiential background of the nurse clinician develops a keen sensitivity to and the ability to help with patients' problems that may lie outside the strictly medical field but which, nevertheless, affects his health. We suggest that in the term "physical extender", the nurses' professional identity is lost. In testimony before House Ways and Means Committee on H.R. 2504, we suggested using the term "primary care providers". In S. 708, the term "primary care provider" would then be defined in section (aa) (3), as stated in the bill.

The success over the past several years of utilization of specially trained nurses giving medical care in otherwise underserved areas of Tennessee is unequivocal in efficiency, cost effectiveness, and quality of care. It is most important that legislation for Medicare funding of these services be responsive to the needs of the primary care clinics, and through them, to all citizens re-

quiring care.

Thank you for the privilege of giving testimony on S. 708.

STATEMENT OF BEN D. BARKER AND ROBERT A. DEVRIES, PROGRAM DIRECTORS, W. K. KELLOGG FOUNDATION, BATTLE CREEK, MICH.

Mr. Chairman: We are grateful for this opportunity to respond as health professionals to the invitation of Senators Clark and Leahy to testify on Senate Bill 708 which would amend the Medicare statute to allow for reimbursement of care provided to rural citizens by physician extenders such as nurse

practitioners and physician assistants. We would encourage your consideration of a three-year trial of Medicare reimbursement to health clinics and ambulatory care centers in underserved communities for primary health services provided by physician extenders who function under but not necessarily in the

presence of licensed physicians.

The problem of obtaining primary health care continues to be of major concern to both the public and the providers of health services. There are major pockets of the country where primary care is simply not available or accessible only at great inconvenience to people. This is particularly so in rural America. While economic factors are of major consequence, it is the absence of professional personnel, especially primary care physicians, that is the principal problem.

Over the last ten years much attention has appropriately been given to the preparation of well-educated non-physician primary care providers generally called physician extenders such as nurse practitioners and physician assistants; the W. K. Kellogg Foundation has supported several such programs. Today there is considerable evidence that such physician extenders working in conjunction with a licensed physician can deliver high-quality primary health services. Through grants made by our Foundation, other private philanthropies and federal sources, models for effective and efficient primary care delivery—

especially in rural communities—are operating.

As an international private philanthropy, the W. K. Kellogg Foundation is presently supporting through grants various models of family practice or ambulatory care centers in attempts to demonstrate the effectiveness of physician-extender services for improving access to quality health services. In the United States these models range from the SOS Health Center in Seeley Lake, Montana, where a nurse practitioner provides emergency and primary ambulatory services under the supervision of physicians miles distant, to family medicine teaching units at Red Oak and Muscatine, Iowa (both related to the University of Iowa) involving nurse practitioners and physician assistants. In each case physician extenders function as team members under a licensed physician in accordance with each state's laws. Under a new Foundation national grant of \$3.5 million to the Hospital Research and Educational Trust, an affiliate of the American Hospital Association, there are just beginning 23 ambulatory/primary care outreach innovative programs by hospitals, medical centers and other eligible community agencies. The majority of these rural health service demonstrations involve the use of physician extenders. A partial list of the Foundation's current commitments for improvement of America's rural health services is appended.

In terms of reimbursement for the services provided by nurse practitioners and physician assistants, we believe payment to eligible ambulatory care centers on the basis of reasonable costs is preferred. Compensation for physician extenders should directly relate to identifiable services whether those services are directly, personally supervised by a physician or are carried out at a site remote from the physician but in accordance with state laws. All eligible facilities should meet the applicable licensing requirements in their jurisdiction and by 1980 should be accredited by the Council on Ambulatory Care Centers

of the Joint Commission on Accreditation of Hospitals.

In terms of qualifying physician extenders whose services would be reimbursed under this legislation, we suggest that they be certified as may be appropriate by the National Commission on Certification of Physicians' Assistants, the National Association of Pediatric Nurse Practitioners or as an adult family nurse practitioner by the American Nurses Association or their successors. Furthermore, all such providers must be legally authorized to provide any physician services as defined by the Medicare law and must be qualified under the licensing laws of their jurisdiction.

In summary, the proposed legislation to reimburse for physician-extender services under Medicare should improve access to quality medical and health services for rural communities. We recommend a three-year trial of these provisions with careful evaluation. The present constraints in Medicare policy limit the effectiveness and efficiency of many of these much-needed rural am-

bulatory health clinics.

Thank you for this opportunity to express our views and suggestions.

A partial list of current commitments for improved rural health services, W. K. Kellogg Foundation

Primary care—ambulatory demonstrations:	Amount of commitment
Health Systems Research Institute	
Unita County Memorial Hospital	60,000
Crook County Memorial Hospital	60,000
Primary care—education demonstrations (nurse practitioner):	
California State College-Sonoma	219, 025
University of North Dakota University of Texas System School of Nursing	266, 140 438, 350
Michigan State University	428, 700
University of Missouri	574, 210
Harding College	401. 325
University of North Dakota	549, 589
University of San Diego	355, 449

STATEMENT OF WILLIAM E. MURRAY, NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION

Mr. Chairman, and members of the subcommittee, my name is William E. Murray. I am coordinator of the National Rural Health Campaign of the National Rural Electric Cooperative Association, the national service organiza-

tion of nearly 1,000 rural electric systems operating in nearly 46 states.

We appreciate the opportunity to make our views known in regard to H.R. 2504 which would amend Medicare legislation to permit Medicare reimbursement for physician extenders in rural areas. The present law prohibits reimbursement of such services unless a physician is present on the premises when such services are rendered. This appears to us to be an impractical prohibition particularly in the light of the serious shortage of doctors and other health personnel in rural areas. We note that the rural health delivery system is deteriorating rapidly and continues to get worse. And unless measures such as the one the committee is considering today and others including realistic financing of the Health Manpower Act passed by Congress last year, are undertaken, the result will be a serious breakdown of the medical care system with devastating consequences for vast segments of rural America and millions of residents particularly young children, the elderly and the poor.

The rural electric systems of the nation have both a direct and indirect stake in this problem serving as they do about 25-million farm and rural people or approximately 45 per cent of the rural population in 2,600 of the country's

3.100 counties.

Ever since their inception in the mid-thirties when only 10 per cent of rural America had central station electricity, rural electrics have been dedicated to improvement of the quality of life in the rural areas. Beginning in the 1960s, when the federal government launched its nationwide rural development program, rural electrics increased their activities in support of efforts—national, state, and local—to help create more job opportunities, community facilities, and services. These accelerated efforts were aimed at slowing down migration from the country-side to the cities. Between 1940 and 1970, it is estimated that rural areas lost about 25-million people.

Impressive progress has been made in rural development on many fronts since the 1960s resulting in thousands of jobs, homes and community facilities of all kinds plus a variety of other improvements. Measured against the needs,

however, these accomplishments represent a modest beginning.

What is significant, we believe, is that rural America is once again gaining population overall. More people are coming back to rural areas than are leaving, which has resulted in a net in-migration of about 2,500,000 during the first six years of the 1970s. Non-metropolitan areas are growing at a slightly faster rate than metropolitan.

The boom in the extractive industries, the increased demand for food, the change in attitude among Americans regarding rural living, and the recession, are all factors spurring the return to smaller communities. The experts expect

the trend to continue.

Federal programs, which NRECA strongly supported, have contributed importantly to this turn-around providing funds for housing, community facilities, job-creating enterprises, and a host of essential services including electric and telephone.

NRECA's main concern in rural development has been with economic growth, community facilities and housing. Recently it has become apparent to us that

health care must assume high priority on our agenda.

Adequate health care is an essential ingredient of rural development. As the legislation before this subcommittee indicates, health care is now a major national problem for which Congress is seeking solutions. While in urban areas it may be primarily a problem of how people are to pay for the care, in rural areas that is only one side of the coin. The other concerns the inadequacy of the health care delivery system which has been well-documented in numerous

studies and in testimony before Congressional committees.

While the problem of financing health care is critical, the first priority in developing an adequate health care delivery system in rural areas, in our opinion, is manpower. And we believe that S. 708 would help importantly in this respect. It would remove the inequitable prohibition under Medicare against reimbursement of the services of physician extenders in rural clinics and thereby stimulate the development of more of these allied health personnel, who, from all accounts, provide high quality primary care. As your bill requires, Mr. Chairman, the physician extenders would work under the supervision of a doctor although they might be located some distance from him. It should be obvious that smaller rural communities generally are not going to be able to get a full time doctor, but a good many of them will be able to get physician extenders or nurse practitioners. The present Medicare prohibition seems to us to be unrealistic requirement. It ignores the fact that there is a severe shortage of doctors in rural areas, and that physician extenders can provide proper treatment.

We are also in agreement with the provisions of S. 708 that permit reimbursement of both profit and non-profit clinics. We believe that a number of doctors in the larger rural communities will be encouraged to establish satellite clinics manned by physician extenders. It is likely that these kinds of clinics can be operational even quicker than the non-profit community type which take somewhat longer to organize and develop. In our opinion, there is an im-

portant role for both types of clinics.

While Medicare reimbursement for physician extenders services would be limited to the elderly who have Part B Medicare coverage — and this will help insure the financial soundness of rural clinics — it is hoped that Medicaid and private insurers will follow this precedent and begin paying for the services of physician extenders. According to studies that we have seen, there is reason to believe that this would result in reduced health costs for rural people and savings for health insurers. The studies point out that there is a reduction in hospitalization for patients who have access to care from physician extenders.

In any case we think it is extremely important that Congress take this first step in changing the Medicare law to provide for reimbursement of physician extenders. It should contribute to increasing the supply of skilled health manpower in rural areas and making good primary care available to many rural people who find it difficult or impossible to get proper medical attention.

people who find it difficult or impossible to get proper medical attention.

Mr. Chairman, in our opinion, this matter of reimbursement of rural health clinics for physician extenders services is a matter of urgency. It constitutes a serious inequity in the Medicare law and should be corrected without delay. Otherwise many of these clinics may have to close their doors which would result in further deterioration of the rural health delivery system. At a time when rural areas are losing doctors, it would be ironic indeed if they should also lose physician extenders.

More important than the financial reimbursement from Medicare is the prospect that this precedent will lead private insurers to reimburse for physician extender services thus making it possible for rural clinics to become self-supporting. It does not make sense for insurers not to pay for physician extender care if it is of high quality and serves the needs of patients. And all evidence substantiates that these skilled health professionals do pro-

vide quality medical service.

Mr. Chairman, I am attaching to this statement a resolution which was adopted at our Annual Meeting last month entitled "Medicare Inequity". This

resolution of the NRECA membership supports the kind of bill which your sub-committee is considering and also urges that health insurers begin to pay for the services of physician extenders.

We appreciate this opportunity to express our Association's views on this

very important matter.

RESOLUTION ADOPTED AT ANNUAL MEETING OF NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION AT ATLANTA, GA., FEBRUARY 24, 1977

MEDICARE INEQUITY

The number of "doctorless" communities is increasing and the prospects that smaller rural towns will be able to get doctors are diminishing even though the supply of physicians is expected to expand over the next decade. The trend is for doctors to practice in groups located in larger rural and semi-rural communities.

Well-trained health professionals known by various names including physician assistants, nurse practitioners, Medex, and others, working under the supervision of physicians are filling a criteria need in "doctorless" communities and are providing a high standard of primary care. There are approximately 1,000 clinics staffed by this type of health professional serving mainly medically underserved areas. More than 16-million rural people live in such areas.

While the services performed by physician assistants in urban clinics where there is a doctor on the premises, are eligible for reimbursement under Medicare, Part B (ambulatory and outpatient care), they are not eligible when provided in rural clinics when a doctor is not present. This means that the rural elderly, who pay \$7.80 a month for Part B coverage, must pay the bill out of their own pockets if they seek care from a physician assistant. This amounts to a bouble bill and undoubtedly inhibits many elderly people from obtaining needed medical care.

Several members of the Senate and House of Representatives are seeking to amend Medicare legislation to permit reimbursement of clinics for services rendered by physician assistants when the doctor who supervises these health professionals is not on the premises. We support these efforts to correct this inequity in the Medicare law, and also urge other health insurers to pay for

such services.

STATEMENT OF JACK M. CORNMAN, EXECUTIVE DIRECTOR AND ALICE S. HERSH, DIRECTOR, HEALTH PROGRAMS, NATIONAL RURAL CENTER

Mr. Chairman, we thank you for the opportunity to testify before your Sub-committee. The National Rural Center, which opened in March of 1976, is an independent, non-profit, non-membership organization created to develop policy alternatives and to provide information to help rural people and their communities.

Through its policy development and information program, the NRC seeks better ways for people in rural areas to voice their concerns and desires, to shape policies affecting them and to gain access to federal agencies and pri-

vate organizations.

Rural health care is one of our top priorities, and welcome the opportunity to provide our input into this important piece of legislation for rural America, S. 708, a bill to amend the Medicare statute to allow for reimbursement for services provided by nurse practitioners and physician assistants.

The Medicare program clearly discriminates against rural areas. In 1972, for example, the average benefit for a Medicare beneficiary living in a metropolitan area was \$425, while the average benefit for a Title XVIII recipient residing in

a non-metropolitan county was only \$296.

There are several reasons for this large discrepancy. First, rural physicians are reimbursed less than their urban counterparts for the same office visit or procedure. This stems from the fact that reimbursement rates under Medicare are related to the usual and customary fees that were charged in the area prior to the Medicare program. Rural physicians have traditionally charged lower fees for a variety of reasons, not necessarily related to the cost of practice. In fact, there is evidence to show that practice in a non-metropolitan area is more expensive than a comparable practice in a large metropolitan area. How-

ever, nationally, rural physicians are reimbursed under Medicare only 60% of

what urban physicians receive.

Another important reason why the rural elderly do not receive their fair share of Medicare benefits stems from the fact that Medicare is only a financing program. It does not provide the delivery system. Hence, in areas where there is no physician, Medicare coverage does little good for the recipient.

This problem is particularly acute in rural areas where the supply of physicians—and especially primary care physicians—is so drastically inadequate. In 1973, large metropolitan areas had one non-federal physician providing patient care for every 500 persons, while small non-metropolitan counties had one non-federal physician providing patient care per 2,000-2,500 people. Clearly, rural people have severe problems of access to care. Despite the fact that this country is training more doctors than ever before, physicians are entering the specialty professions and are locating in urban and suburban areas which already have more doctors than accepted standards say are necessary.

A third way in which the Medicare program is biased against rural areas is that it does not recognize nurse practitioners and physician assistants as eligible providers of Part B services. As previously stated, Medicare only pays for the care, it does nothing to encourage or ensure providers are available. In rural areas where the supply of physicians is so inadequate, it is especially critical that Medicare recognize and encourage alternate delivery systems and new

providers.

Many rural elderly receive their care from nurse practitioners (NP) or physician assistants (PA), yet these non-physician providers cannot be reimbursed by Medicare when a physician is not physically present at all times

and directly supervising the NP or PA.

In some rural areas, populations are so sparse that a community could never attract or financially support a physician, but could support a small primary care clinic staffed by an NP or PA working under the general supervision of a physician, if third party insurers recognized these non-physician practitioners as reimbursable providers. The quality of care provided by these non-physician professionals has been well documented, and communities are very accepting of them.

Nevertheless, the rural elderly who are receiving care from NP's or PA's—many of whom would be totally without any source of medical attention were it not for the NP or PA—are being penalized. While over 95 percent of the elderly pay their monthly Part B premium, beneficiaries receiving care from the NP/PA are billed again by the clinic because Medicare will not reimburse for care provided by someone other than a physician. Hence, they are paying twice for their care. This is clearly unfair, especially in light of the fact that a disproportionate percent of rural people are elderly and poor and totally de-

pendent on publicly financed health care programs.

There is still another paradoxical aspect to this policy. On the one hand, the federal government pays millions of dollars to train NP's and PA's, and encourages their use through such programs as HMO's, Rural Health Initiative projects, Health in Underserved Rural Area projects, and Appalachian Regional Commission clinics. At the same time, another federal agency does not reimburse NP's and PA's for the services they provide. Moreover, all the aforementioned programs require self-sufficiency after some set period of time, but obviously clinics will not become financially self-supporting if their providers cannot be reimbursed. Clearly, the government is working at cross purposes. We commend you, Mr. Chairman, for your leadership in seeking to rectify this inequity.

We also feel it is important to emphasize that while changing the Medicare policy is a critical first step and will hopefully provide a precedent for other public and private third party insurers, this change alone will not solve the financial problems presently facing rural clinics. Unless Medicaid and other third party insurers also recognize NP's and PA's as reimbursable providers, rural clinics will continue to have great difficulty becoming financially self-

sufficient.

We strongly endorse your bill, Mr. Chairman, because you not only propose to amend Medicare to allow for reimbursement of services provided by NP's and PA's, but you also propose to reimburse for the services on a cost-related basis. If the ultimate goal of this legislation is to encourage viable rural

health systems, then it is imperative that reimbursement be provided at a level that reflects the true cost of providing care in a given clinic rather than

on the basis of the fees that were traditionally charged in the area.

We support S 708 in expanding Medicare to provide for reimbursement of NP/PA services on a cost-related basis. However we recommend that the physician services in the clinic also be included as an allowable clinic cost. As the bill is written, it seems to require the supervising physician to receive separate reimbursement on the old charge basis through his or her Medicare provider number. As stated earlier, the ultimate goal of S 708 should be to help develop financially-sound health systems. This cannot be accomplished if we continue to reimburse the clinic physician at a rate which bears no relationship to the actual cost of his or her services. Because the clinic budgets will be regularly reviewed and physician services could be reimbursed on some salary equivalent basis, we feel the bill contains sufficient safeguards against physicians exploiting the program, the NP or PA or the patients. Moreover, keeping two separate billing systems—one for the NP/PA and one for the physician—will place an undue administrative burden on clinics which are already struggling with administrative problems.

Regarding the definition of rural health clinic service, S 708 is unclear as to whether it would expand the Medicare Part B benefit package to include,

for example, preventive services.

We urge that these services be covered by the bill. Numerous studies are available to prove the cost effectiveness of preventive services, the most recent study commissioned by the Appalachian Regional Commission and conducted by the Mitre Corporation. Data proves unequivocally that preventive care reduces long-run hospitilization costs. On this basis, and on the basis of our general belief that the goal of our health system should be to keep people well instead of merely treating patients once they are sick, we support the coverage of preventive services to Medicare beneficiaries receiving care from clinics covered under this bill.

We endorse your definition of a rural health clinic. The definition is flexible and realistic while containing quality control mechanisms. We do however question the requirement for "utilization review". While we recognize the need for some quality review mechanism, we are unclear as to what "utilization review" (UR) would mean for a small primary care clinic, and fear that regulations may place unrealistic demands on the clinic. For this reason, we

support deleting this requirement.

Before concluding we urge you, Mr. Chairman, to add one provision to your bill, i.e. a grandfather clause to ensure that clinics cannot be dropped from the program if the area in which it is located loses its MUA designation.

Again, Mr. Chairman, we commend your leadership in this area and thank

you for the opportunity to express our views to this committee.

STATEMENT OF THE NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES

Mr. Chairman and members of the subcommittee, the National Federation of the Licensed Practical Nurses thank the chairman and members of the Subcommittee for this opportunity to comment on the need for Medicare Re-

imbursement of Physician Assistant Services.

We are the professional organization which represents Licensed Practical Nurses. Currently there are more than 550,000 in the United States. We have a keen interest and great concern for those in need of health care services. We have observed first hand the needs of the medically deprived who live in underserved areas of our country. We have watched as some of these medical services have deteriorated because of the current federal policy of not reimbursing providers with Medicare funds and are fearful of the survival of some health services if there it not a change in policy and if legislative action is not taken.

We intend to use this opportunity to emphasize our strong support for S. 709. You have had the testimony and statements of many knowledgeable people. We are sure that you are aware that the administration has proposed, in the 1978 fiscal budget, that \$25 million be used to provide this Medicare coverage of services provided by nurse practitioners and physician's assistants in primary health clinics. You have available the reports of the Rural Development Subcommittee field hearings and of your colleagues on a counterpart subcom-

mittee in the House of Representatives. The Department of Health, Education and Welfare has publicly stated to the Subcommittee on Health, House Com-

mittee on Ways and Means that they support such legislation.

Our organization would like to publicly go on record favoring the passage of S. 709 to correct the inadequate coverage of third party reimbursement and, indeed, would urge the subcommittee to give serious thought and consideration to further extending this coverage to include the services that are provided by educationally prepared Licensed Practical Nurses.

As members of this subcommittee are no doubt aware there has been steady progress and upgrading the education and professionalism of Licensed Practical Nurses. The Licensed Practical Nurse profession has proven its worth in the pragmatic world of relieving human misery and suffering. We have been schooled in the basics of health care and nursing techniques in both the field and in the classroom and exercised our training in various health facilities.

Our members are successfully engaged in many rural health clinics, especially in home health care situations, and have first hand knowledge of the present deficiencies in the law, and therefore applaud the intent and mandates of S. 709 as it would amend Title XVIII of the Social Security Act. Many of the health care situations in which we are involved are staffed by Licensed Practical Nurses and our usefulness could be magnified by the extension of

coverage to also include the professional services which we provide.

With the staggering work load of many physicians and their apparent scarcity in rural and other underserved areas, it would seem that other health professionals would be logical and frugal substitute. These clinics are under the supervision of physicians and are able to make better use of the sophisticated means of communications now available. Care administered by health providers are often dictated by specialists who are many miles away. If we have these avenues available and can use them to lessen a medical problem or save a life, we ought to be progressive enough to make them legislatively and economically feasible and be able to implement them efficiently. There is always the danger that we will shunt progress because we neglect to take a simple step or two that will align the rules with the needs and solutions.

Modern day practical nursing has become more sophisticated in recent years. Our profession has come a long way since the time that just anyone could

be called into a sick room or hospital.

In 1977 we look at even a most humble rural health center and see it as a place where preventive medicine is routinely practiced, where treatment prescribed by a physician can be carried out according to his dictates but which do not necessitate his presence. The degree of excellence of the practical nursing course in accredited schools prepares dedicated people for their chosen occupation.

The federal government is making progress in focusing on the problem of serving the health needs of those in underserved areas. This bill will go a long

way to make that task easier.

One cannot fault the physicians for this situation because there are so many noble, bona fide opportunities for them to serve a variety of health needs. While we see the need of the few in isolated areas or the many in inner city ghettos, there are also the many in suburbia to be served as well as the research and the teaching to be done. This is exactly why the National Federation of Licensed Practical Nurses can wholeheartedly urge the passage of this measure. It not only permits the physician to work where he or she might be most needed but would also allow more of them to share their time and expertise with other health providers who work in health satellite units. This is one economical and efficient way to dote to the perennial shortage of patient-serving personnel.

If this bill is not passed, we fear the almost complete collapse of this fine network of medical clinics. Many of these federally established satellites will soon be forced to operate on their own as their seed money will no longer be granted. Also, if the patients are not reimbursed by Medicare they will either not be able to pay for these needed services or worse they will dis-

continue receiving nursing care.

Likewise, if this measure is not passed, new costs will appear — such as the dollars needed for transportation to take patients to facilities where Medicare will furnish services. Added to this will be the intangible cost in time and discomfort and treatment involved in transporting an ill person. It scarcely needs to be pointed out that there would be a toll in insecurity for people who may be aged and bewildered, and in fear of the unknown and unfamiliar. Also

it would be a traumatic experience for some to travel from their parochial surroundings. One can only speculate how many of these patients would simply

ignore their health problems and cease to seek advice and treatment.

In the chain of events that may occur in unsupervised home treatments, patients would suffer dire results if they are given, for instance, a large supply of medication and consume it in over-accelerated rate. Also other types of medication which could be administered only in a local satellite clinic might not be available to the average citizen. The new and needed approach of permitting third-party payments seems to be a sensible approach to a problem which already seems to be solvable with the availability of skilled and educationally prepared health providers.

The National Federation of Licensed Practical Nurses urges the passage of S. 709. We further urge the subcommittee to begin thoughtful and serious consideration of including the services of Licensed Practical Nurses who are prepared to deliver quality health care where ever and when ever needed and such services should be considered under Title XVIII of the Social Security

Act.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
Atlanta, Ga., March 18, 1977.

Hon. Dick Clark, Chairman, Senate Rural Development Subcommittee, Russell Bldg., Washington, D.C.

Dear Sir: The lack of equitable reimbursement by medicare for physician supervised extender services is a problem in all clinics where the physician is not physically present. This is of paramount importance in establishing and maintaining physician extender clinics in isolated rural areas. There are a number of these small rural community primary health care centers located in this Appalachian Region. These innovative health care delivery prototype have steadily increased in the last four years through grant and foundation resources. Even with this thrust, however, there is still a definite lack of enough health services available to Appalachians in rural areas. The regulation that prohibits medicare reimbursement for the physician supervisor extender clinics is causing a serious financial problem for all established clinics seeking financial viability. There are not only limited resources for establishing clinics but restrictive time factors which place the clinic in a continuing role of searching for more government or foundation monies.

The medicare law should allow for equitable reimbursement of extenders whether the supervising physician is onsite or not. Care should be taken, however, to insure that extender personnel are properly trained to perform those tasks assigned to them and that procedure and protocols under which

they function are clearly defined.

The clinics on which I have based this testimony provide a broad range of personal health services including: promotion and maintenance of health, prevention, basic care during acute or chronic phases of illness, guidance and counseling for individuals and families and referral to other health care pro-

viders and community resources, when appropriate.

Some of our supported centers have a physician; however, many are too small and too isolated to support a full-time physician. These rural primary care clinics are all providing personal care services as outlined above. In each clinical situation the extender provider is working in close association with a

primary care physician.

Time is running out for the rural clinics in Appalachia. Funding sources, both grants and foundations, will not continue indefinitely. Legislation which will amend Title XVIII of the Social Security Act to allow medicare reimbursement for primary health care services for physician supervised extenders will certainly be one of the answers in a clinic's quest for financial viability.

If there is any other way that I can provide additional information or assistance in securing this piece of legislation, please do not hesitate to call on

me.

Sincerely yours,

JACOB M. SMITH, JR., Regional Program Consultant, Office of State Coordination (PHS). OHIO MID-EASTERN GOVERNMENTS ASSOCIATION, Cambridge, Ohio, March 23, 1977.

MR. DAVID HARF: Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: I would like to comment on the professional opinions of several providers of health services in the OMEGA district regarding the use of physician extenders:

1. How would legislation of this sort assist small communities in your area

and throughout the country?

Reimbursement for the services of nurse practitioners and physician assistants would make it possible to provide services to the senior citizens, and to keep the present staff. In some cases additional physician assistants could be hired. One area is already part of an experimental program, "Coordinated Outreach Screening Program". The Nurse Practitioner is being reimbursed for services through the agency and the program appears to be very successful.

2. In what manner should reimbursement be made for the services provided

by nurse practitioners and physician's assistants?

All of the health service providers preferred agency reimbursement with

emphasis on a comprehensive service and team approach.

3. What requirements should a clinic fulfill, in terms of such factors as physician participation, arrangements for referral, and management policies,

in order to qualify for reimbursement?

While one respondent felt it was ideal for a physician to be available at all times most of the providers thought a team approach with the physician responsible providing written, current, standing orders, delegated duties and outlining treatment procedures was best. Referral contacts should be arranged in advance and be made by a member of the team. Management policies should be determined by the health team and administration staff.

4. What type of certification process should be used for the providers whose

services would be reimbursed under this legislation?

Certification should include clinic, medical personnel and school providing the training. One respondent thought the Ambulatory Health Care Center certification was too extensive and detailed. The section of the mechanical setup of clinic is helpful.

All respondents suggested formalized, consistent (quality and content) training, examinations and recertification. Continuing education should be manda-

Sincerely,

(Mrs.) Julia W. Wallace, Child Development Director.

AETNA LIFE & CASUALTY, Co., Hartford, Conn., March 21, 1977.

Mr. David Harf, Office of Senator Dick Clark 404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: Ætna Life & Casualty respectfully requests that this letter be included as part of the record to be prepared as the result of the hearing

on S. 708 to be held March 29.

Ætna Life & Casualty fully supports the principle, embodied in S. 708 of allowing Medicare reimbursement to rural health clinics for primary health services. As the administering carrier for Part B of Medicare in Alaska, Arizona, Hawaii, Nevada, Oklahoma, and Oregon, we are acutely aware of:

(1) The fine service being rendered by existing rural health clinics;

(2) The need to encourage the formation of more such clinics; and(3) The inequities caused by Medicare's current inability to pay for the

services of such clinics.

With respect to S. 708 itself, we believe there is a typographical error in the full paragraph that follows subitem (aa) (2) (H). This paragraph currently makes little sense because it reads: "For purposes of this title, such term includes only a facility which is not located in an urbanized area (as defined by the Bureau of the Census) where the supply of medical services is not sufficent to meet the needs of individuals residing therein. . ."

It would seem that the phrase "not located in an unbanized area" should read "located in a rural area."

Subject to the above and any other necessary technical changes, we urge enactment of S. 708.

Sincerely,

DANIEL W. PETTENGILL, Vice President, Group Division.

[Western Union Mailgram]

ALBANY, N.Y., March 25, 1977.

Senator DICK CLARK. Senate Office Bldg., Washington, D.C.

Senator Clark: NYSNA, representing professional nursing in New York, strongly urges you to replace the word "supervisor" with the phrase "physician consultation" in S708. We not only support collaboration, consultation, and referral between nurse practitioners and physicians, but see this relationship as vital to comprehensive health care delivery. Nurse practitioners stand ethically and legally committed to the rights of consumers to quality services.

We strongly support this proposed modification in medicare reimbursement

policy and the general approach taken by the committee.

Again we strongly urge you to modify \$708 by substituting "physician consultation" which is reimbursable for "supervisor". Thank you.

Dr. Veronica Driscoll, R.N., Executive Director, New York State Nurses Association.

DECATUR COUNTY AREA CHAMBER OF COMMERCE, Oberlin, Kans., March 21, 1977.

DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR SENATOR CLARK: We are a rural town in Northwest Kansas and a rural community. The population of the community is approximately 5,500 people. We here at the Decatur County Area Chamber of Commerce represent a good number of those people in as far as the thinking is concerned on rural health developments. We are very interested in Senate Bill 708. We have learned, as you have, that medicare policy prohibits coverage of health services

provided by nurse practitioner's and physicians assistant's.

To us here in a small community this is grossly unfair to our people. We, at the present time, have two physicians assistant's employed in our community. We feel that they are valuable people in the respect that they are very useful when it comes to helping, especially our older people who need medical attention and for reasons of health are unable to wait for long periods of time in a clinic for medical attention. At the present time we have only on doctor in Oberlin or in Decatur County. These physicians assistant's are helping with the medical load of one physician. As you know, if you are going to take 5,500 people and one physician is going to take care of all these by himself, this is a load that is impossible for any one man to bare.

We think it is important that the medicare policy be changed and these physicians extender's be allowed to treat people under medicare in the areas in which they are qualified to do so. It only makes sense to me, that with the doctor shortage such as we have, that communities that can take advantage of physicians assistant's and nurse clinician's would and should do so in regards

to health services for their people.

Please give these comments consideration as you take time in the hearing to work on bill S 708. Thank you very much for giving us the opportunity to contact you on this matter.

Sincerely.

KEN RYDQUIST, Manager, Decatur County Area Chamber of Commerce.

[Western Union Mailgram]

ITHACA, N.Y., March 27, 1977.

RICHARD CLARK, Senate Office Bldg., Washington, D.C.

SENATOR CLARK: Urge revision of S-708, rural clinics reimbursement as follows: Replace "physician supervision" with "physician consultation which is reimbursable."

Rural New York nurses are independently presently providing health care with physician consultation and have proved their expertise in assessing when physician involvement is needed. The physician supervision clause of S-708 is regressive and prohibits expansion to numerous unserved areas.

District 7, encompassing 3,000 nurses, urges prompt passage of S-708 with the

above revision.

Sincerely.

JOANNE BYRNES, President, District 7.

St. Charles Community Health Clinic, St. Charles Health Council, Inc., St. Charles, Va., March 28, 1977.

DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: My comments concerning S. 708, a bill to permit Medicare relmbursements to rural health clinics for primary health services, will be brief.

The St. Charles Community Health Clinics is a rural health clinic owned by a non-profit community corporation and provides rural health services in a medically underserved area in Southwest Virginia. The corporation employs a full time internist, a certified Virginia family nurse practitioner, and appropriate management and support staff. The physician admits his patients into two local hospitals. The nurse practitioner and the physician refer patients to other physicians for specialty services. The physician has obtained a "permitted physician" license from the State Board of Pharmacy and dispenses drugs from the clinic pharmacy.

The clinic serves a population of four thousand people comprised mainly of working, retired, or disabled coal miners and their families. Over seventy per cent of the monthly clinic patient visits are covered by third parties. The clerical staff spends a considerable amount of time billing Medicare, Medicaid, Southern Labor Union, UMWA FUNDS, Blue Shield, and private insurances. Over twenty per cent of the total visits are covered by Medicare. The staff spends a disproportionate amount of time billing Medicare for covered services; billing patients rather than Medicare for services provided independently by the nurse practitioner; asking reconsideration on disallowable charges, explaining EOMB statements to patients, and collecting deductible, coinsurance, and noncovered charges from the patient. I have not computed the cost of providing services plus billing Medicare compared to the Medicare reimbursements and patient payment, but I can be reasonable sure that the clinic comes up on the losing side.

The physician provides care at the clinic and two hospitals. Based on the competency of the nurse practitioner, he finds it unnecessary and impractical to be present to see every Medicare patient in the clinic or on home visits. The nurse practitioner provides a valuable service to home bound Medicare patients. This service would be unavailable if it were dependent on the physi-

cian's time.

We will not deny any service to our Medicare patients, many of whom helped to finance and build the clinic. We will not force those individuals on fixed incomes to pay their entire bill if they prefer to see the nurse practitioner or if they receive routine services (e.g. Pap tests) which are currently not covered by Medicare. However, at the same time we must become self-sufficient when our Rural Health Initiative grant expires.

The St. Charles Clinic is in full support of S. 708. We believe that the provisions for the reimbursement on a reasonable cost basis payable to the non-

profit corporation for rural health clinic services will alleviate some of our billing problems, increase our amount of reimbursement, and brighten our

prospects for self-sufficiency.

Perhaps the most important point to be made concerning our experience with a nurse practitioner is that she is providing a valuable primary care service that complements the service provided by our internist. The truth is that many of our older patients prefer to see the "little woman doctor" because she has demonstrated her competency, developed her own professional relationships with her patients, and is willing and able to listen to their problems.

Sincerely,

NANCY RAYBIN, Administrator.

WINNEBAGO COUNTY NURSING SERVICE, Forest City, Iowa, March 23, 1977.

Senator Dick Clark, Chairman, Senate Rural Development Subcommittee, U.S. Senate, Washington, D.C.

Dear Senator Clark: I support the bill S. 708 which would allow Medicare reimbursement for primary health services in rural areas. As the public health nurses in Iowa are receiving additional education in adult physical assessment, it becomes more and more evident that these nurses are well qualified to do primary and secondary care under the direction of the physician involved.

The main concern of the public health nurse is prevention of critical health problems. By so doing, many tax dollars of federal money can be averted.

Sincerely,

MARJORIE COSTIGAN, R.N., Director.

[Western Union Mailgram]

PASCOAG, R.I., March 28, 1977.

Senator Dick Clark, 404 Russell Bldg., Washington, D.C. (Attention David Harf).

DEAR SENATOR CLARK: It has come to our attention that your rural development committee is holding hearings on S-708 Rural Health Clinic bill for the purpose of amending title 18 to allow reimbursement for services rendered by nurse practitioners and physician extenders in the absence of an on site physician.

The very nature of many problems associated with rural populations is the absence of services, including health care providers. It has been repeatedly demonstrated that nurse practitioners etc operating under established protocol can

and do provide excellent health care.

Our H.U.R.A. program depends on the utilization of nurse practitioners. We support wholeheartedly any and all legislation that will allow for high quality cost effective health care which can be brought one step closer with the adoption of the amendment.

Yours truly,

A. Betsy Pepper, R.N.. Director, Northwest Community Nursing and Health Service.

> Hot Springs Health Program, Hot Springs, N.C., March 23, 1977.

Senator Dick Clark, 404 Russell, Washington, D.C.

Dear Senator Clark: I am aware that you are sponsoring Senate Bill S-708. As a nurse practitioner working with the Hot Springs Health Program, I will share with you my experience with rural health care, and my sentiments about Senate Bill S-708.

I work with a rural health program in a county with 13% of its population aged 65 and older. The program serves 35% of the county's population, and if funding is received this year, will expand to serve 56% of the population. There

are four full-time doctors in the county. Three are in private practice and do not fill out Medicare forms; thereby they do not serve the Medicare population. The fourth doctor works with the Hot Springs Health Program, which does provide services for Medicare recipients. This doctor is my supervising physician and provides medical backup so that I may function as a nurse practitioner in one of the satellite clinics. The physician rotates to this clinic on two days when he attempts to see the Medicare patients who have appointments. This fails to provide adequately for all Medicare patients, especially

those who need care on the days the doctor is not present.

I see the present system of Medicare reimbursement as discriminatory against rural America, and especially against the rural elderly. But, perhaps, more ironic, and sadder still, is the discrimination against nurse practitioners and other physician extenders. I cannot understand how the same government which helped to fund my education as a nurse practitioner, thereby encouraging me to believe that I am competent to deliver primary health care, now refuses to reimburse my services unless I am acting under the supervision of a physician in his presence. When a patient, who I've been seeing independently yet with the supervision of a physician, comes to the clinic on a non-doctor day I have to tell him that for my services on that day he/she can expect neither Medicare payment nor an accrual of the amount he/she must personally pay before receiving Medicare's medical benefits. This says clearly to the patient that my services as a practitioner are second rate, and not worth paying for. The plight of the elderly affects the rest of the community — their sons and daughters, their grandchildren — who are subtly influenced to think that the nurse practitioner does not give top rate professional health care. It is important that a single, uniform federal policy regarding health services provided by physician extenders be established if the concept of physician extenders and their role in health care becomes a reality.

I am proud of the model the Hot Springs Health Program has provided. Our county is rural and culturally and geographically Appalachian. It has problems attracting doctors because of its isolation and its poverty. It is the 4th poorest county in North Carolina. But its people still get sick and they want their children to have healthy lives. Our solution has been nurse practitioners. We have struggled to overcome a bias toward physician preference and have gained the confidence of the people. I feel that I, and my colleagues, pro-

vide competent, quality health care.

I hereby endorse the bill you are sponsoring.

Sincerely,

GINNY KORANEK, R.N., F.N.P.

THE WESTERN MONTANA CLINIC, Missoula, Mont., March 15, 1977.

Re S. 708.

Senator Dick Clark, Chairman, Senate Rural Development Subcommittee, 404 Russell Bldg., Washington, D.C.

DEAR SENATOR CLARK: Thank you for the invitations to testify on S 708.

I am a pediatrician practicing in a forty-five physician multispecialty clinic in a community of approximately 55,000. We serve a medical catchment area of

approximately 170,000 within an approximate 100 mile radius.

Within our medical catchment area there are many small communities who will have the potential to benefit immensely from your proposed legislation. Specifically, I could see an organization such as ours associating with a rural clinic, which has one or two full time resident physician extenders. We could provide daily supervision, review and consultation with either a primary care physician (pediatrician internist or gynecologist) or an occasional visit by a specialist, such as a surgeon, ENT or orthopedist. This would enable a community to first, have immediate emergency medical care available, have the benefits of continued continuity of medical in their community, along with expert specialist knowledge and skills.

In my opinion reimbursement should be fee for service to the legal entity providing the services. In some cases this may well be a nonprofit community organization, or in others it may be a private physician or clinic which likes to establish the satellite. I think it would be unwise to directly reimburse in-

dividual physician extenders.

I concur with your present definition of a rural clinic relative to requirements for physician participation, etc. As you undoubtedly know, most states also have laws which address this issue.

I believe it is unnecessary for the federal government to directly certify clinics as long as they first, meet the definition of rural clinic as outlined in your bill and secondly, meet the medical practice laws of the state.

In summary I support the intent and substance of your bill, and I believe it will directly benefit the provision of rural health care in Western Montana.

Sincerely,

KIT JOHNSON, M.D., M.P.H.

MEDICAL CARE DEVELOPMENT, INC., Augusta, Me., March 16, 1977.

Hon. Dick Clark, U. S. Senate, 404 Russell Bldg., Washington, D.C. (Attention David Harf).

DEAR SENATOR CLARK: The following statement regarding S. 708 is submitted as testimony to be included in the record of the hearing to be held on March 29, 1977 regarding Medicare reimbursement of rural health clinic

services.

S. 708, a bill to permit Medicare reimbursement to rural health clinics for primary health services, is a vital and necessary element in constructing an effective health care system for America's rural communities. The solo practitioner model is no longer a realistic or effective way of providing preventive and curative services in the sparsely settled areas of our country. Community-based and community-sponsored health centers, using new technologies and new types of physician extender manpower and with well-defined linkages to sources of higher level medical care, now appear to be a more viable twentieth century approach to providing good medical and health care in rural areas. It makes little sense to wish that we could return to yesterday and force individual physicians to live and practice in these isolated settings.

The system of training physicians in the United States is changing its focus from specialty care to primary care. These new physicians, however, are not being trained to duplicate the solo practices of fifty years ago. Rather, they are being trained to manage the delivery of care through a structure health care team, with each member having well-defined roles. Physician extenders

are most important parts of these teams in rural areas.

Rural communities have limited financial bases for supporting these needed rural health care systems. If they do represent a more effective way of meeting a rural community's health needs, and we believe that they will prove to do so, then all of the possible sources of financial support must participate. Medicare's failure to participate in the past has seriously jeopardized efforts by

rural communities to provide for their health care.

S. 708 will provide an important segment of the financial foundation for operating rural health centers and is a start toward rectifying the unjust present geographic expenditure pattern of the Medicare Program. Because of the proven correlation between density of medical resources and Medicare expenditures, it is doubtful that per capita Medicare expenditures in rural states will move very much closer to those in urban states even with this amendment. We would therefore suggest that the Medicare amendments also include a specific provision for support of preventive health activities as a fixed percentage of the yearly curative care expenditures in rural health care centers. This would help to both equalize the Medicare expenditures in rural and urban areas and provide a preventive focus to the development of rural health systems that should tend to reduce health care costs in the long run.

In addition, the following suggestions are offered for your consideration:

(a) The condition of quality control, specifically the nature of physician supervision, should be carefully delineated to assure that no one is subjected to second class medical care.

(b) The specific condition of physician supervision should take into consideration the limited physician manpower in rural areas and the potential of

telecommunications for shrinking the distance between the physician extender

and the physician.

(c) The development of community-based medical education activities under the new manpower legislation could provide an essential element of support to the rural health system development effort. Creating an educational program around the better, new and experimental health centers could make them much more attractive places to practice for both physicians and physician extenders.

(d) Very few of the experimental rural health care efforts started through the Rural Health Initiative, Community Health Centers, and Health Underserved Rural Areas programs can survive without payment from Title XVIII.

In the State of Maine, we have found a high degree of receptivity in the rural communities for new approaches to health care. Health care costs and preventive issues are usually secondary to the fear that no source of care will be available in mergencies, but they grow in importance when this basic need is met. The Medicare program can play a major role in the success or failure of these new rural health care systems, and the decision to support their modest costs now can lead to much greater long-term savings of health care dollars in the future.

We appreciate the opportunity of submitting this testimony and would be pleased to appear before the committee at any time, if it would be helpful in rectifying the inequity caused by the present Medicare law.

Very truly yours,

MANU CHATTERJEE, M.D., Executive Director.

BLUE HILL CLINIC, Blue Hill, Nebr., March 25, 1977.

Re Rural Health Clinic Bill S. 708.

Mr. DAVID HARF.

Office of Senator Dick Clark,

404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: I have been practicing in the small town of Blue Hill, Ne., population 1200, for 22 years. The nearest doctor and hospital to the south is 22 miles, and 20 miles to the north. The nearest doctor to the west is 45 miles and to the east is 60 miles. This is in South Central, Ne., 25 miles north of the Kansas border. I have roughly 7,000 active patient charts in my files.

The situation in the last 20 years has only continued to deteriorate instead of improve, so far as the supply of medical services to the area is involved. Until 10 years ago I had a second physician in practice with me, and since then I have not been able to come close to interest another physician in spite of the need. One year ago I did hire a Physician's Assistant who was graduated from the University of Nebraska Physician's Assistant Program,

and is fully certified by the national exams.

Since I also practice in an area that has one of the highest percentages of elderly people in the nation because of the increased productivity of the farmers, the young people have had to leave the area, thus creating a higher and higher percentage of old people. I am the only physician to provide coverage for the Nursing Home of 67 beds in Blue Hill, the Nursing Home of 55 beds in Campbell, Nebraska, 25 miles away, and the Nursing Home of 54 beds in Edgar, 35 miles away. This will give you some idea of the problem I must have trying to justify a Physician's Assistant if Medicare does not reimburse

The bill proposed I feel is absolutely essential if the Physician's Assistant is going to be a functional part of medical services in rural areas. The requirements proposed in the bill for the reimbursement I think are entirely within reason, and, as a matter of fact, Nebraska's laws governing the practice of Physician's Assistants even require the Physician's Assistant to be directly supervised at all times, and that he cannot practice in satellite clinics without

the supervising physician being present.

The only exception I would vigorously take to the Bill is the method of reimbursement. By the time the bureaucrats get through with the cost-related method of reimbursement, I am sure I will have to hire a full time accountant to provide adequate figures to prove my cost of the Physician's Assistant. If the Physician's Assistant concept is valid, then the Physician's Assistant's services should be reimbursed the same as if I performed those services myself. If they are not worth the same, then this indicates that the services provided by him are second rate services, and not the same quality of medical care. The services that he needs additional help with of my personal time are charged the same as if I performed the services myself, and the services he can do alone are charged the same—any other method of charging seems unfeasible and incongruous to me. If reimbursement for cost is the method, what I want to know is—is the Accountant's expense a reimbursable cost? Personally, I feel the patients are getting better care now because I have more time to spend with the problems that require my time, and he provides the same quality care in the areas that he functions in — that saves my time. I feel that States such as Nebraska that require the Physician's Assistant to be immediately supervised and not able to practice in satellite clinics alone, should be reimbursed on the same basis as the physician.

Thank you for the opportunity to present my feelings on the matter. I hope this arrives in time to be of some help, but I did not receive it on my desk

until March 24th.

Sincerely yours,

FRANK KAMM, M.D.

[Western Union Mailgram]

SEATTLE, WASH., March 24, 1977.

Senator DICK CLARK, Capitol One. D.C.

This is to express my appreciation for your sponsorship of S708 for rural clinic reimbursement and to request your favorable consideration of an amendment to replace the word "supervisor" with the phrase "physician consultation" which is "reimbursable". Nurse clinic provides needed services in many communities their physician "supervision" is not available. Consultation, by phone and periodic direct contact, would be less restrictive and provide the desired position/nurse practitioner collaboration.

Louise Shores, President, Washington State Nurses Association.

METH-WICK MANOR, Cedar Rapids, Iowa, March 17, 1977.

Hon. DICK CLARK, U.S. Senate, Washington, D.C.

DEAR MR. CLARK: I have read through the bill S 708 you sent and agree that the rural areas of the nation and Iowa need something like this.

The only comment I have is on section (H) "Has appropriate procedures for

utilization review."

When this phrase has been used in relation to Nursing Homes, it has meant a physician reviewing the utilization. This raises a problem since the physicians are not in the community. If they were you would not need the Health Clinic and its "physician extender". If in order to be paid by Title XVIII or Title XIX funds, section (H) needs to have some clarification. If you don't have utilization review, will you be paid? If you can't get the physician or proper person for utilization review, will you be paid? Sometime the Health Clinic would not be at fault in trying to have utilization reviews.

Sincerely,

ROBERT RIGGS, Executive Director.

DEPARTMENT OF SOCIAL SERVICES, STATE OF IOWA, IOWA SOLDIERS' HOME, Marshalltown, Iowa, March 23, 1977.

Senator Dick Clark, Chairman, Senate Rural Development Subcommittee, U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: Thank you for continuing to inform me about the status of the rural clinic bill, S. 708. I am pleased to learn a hearing has been scheduled and that the bill does seem to have good support.

The concept of using non-physicians to provide primary health services is legitimate and should be promoted. I would prefer these clinicians be called by their respective titles, i.e. physician assistant, nurse practitioner, as their roles are not synonymous and the rural clinics should do more than provide substitute physician services. Primary care should help a person utilize his personal resources to prevent illness or at least deal more effectively with impending illness. "Sick" care should be less prevalent with effective primary health care. Furthermore, clinics should be monitored to ascertain that preventive care is indeed the focus of the clinic.

The reimbursement language of the bill is broad and I see this as advantage.

The reimbursement language of the bill is broad and I see this as advantageous. I would hope reimbursement would not be restricted to care provided within the confines of the clinic. For example, the nurse practitioner would probably want to do rehabilitation teaching in the client's home where she could assess his actual living environment and plan with him how to best cope

within this environment.

I think it is important the clinics become a model for providing quality care that is not dependent on high technology. There is little control over this with competitive health care and too often continued access to care depends on being able to affort its high costs. For example, persons who are high-risk for urinary tract infection should have regular follow-up instead of waiting to treat actual infections. Clients can be taught to do self-screening with a urine dip-slide and when it is safe and appropriate, the dipslide can also be used in place of urine culture that depends on expensive, hospital laboratory procedure. I do not believe we can justify our emphasis on procedures like dialysis and kidney transplant and yet fail to provide preventive care for the general population.

A rural clinic obviously needs access to and the support of the nearby medical staff and hospital. The medical community should be invaluable in helping identify criteria for quality care in these clinics. However, reimbursement of the rural clinic staff should not be dependent on the physical presence of a physician. The clinical practice of all health professionals should be subject to review by their colleagues, clients, and other professionals. This means the nurse should be assessed by other nurses and the public, not just by physicians as the bill seems to suggest. Incidentally, this same criteria should apply in private practice and one does not have to look far to find incompetent pro-

fessionals that are not subject to such review!

It is reasonable to utilize the American Nurses' Association certification standards for nurse practitioners. I believe that nurses certified in areas other than Adult-Family Nurse Practice should also be considered for these clinics. For example, Iowa has a large elderly population and there are a number of nurses at the Iowa Veterans Home that are certified by the American Nurses' Association in gerontological nursing. The specialty possessed by these nurses could be utilized in rural clinics as could the special knowledges possessed by other clinicians.

The rural clinic bill should be a positive step towards promoting preventive and maintenance health care. I would hope this will be its focus rather than

one of providing pseudo-physicians for rural areas.

Sincerely,

 $\begin{array}{c} \text{Ann Cordes,} \\ \textit{Nursing Advocates, Iowa Veterans Home.} \end{array}$

PANHANDLE HEALTH DISTRICT I, Coeur d'Alene, Idaho, March 21, 1977.

Senator Dick Clark, Chairman, Senate Rural Development Subcommittee, 404 Senate Office Bldg., Washington, D.C.

Dear Senator Clark: We understand that you, Senator Church and others are sponsoring S. 708 which will help to expand Medicare reimbursement to include rural health clinic services. As a non-profit public health clinic providing public health services in an isolated rural environment, we certainly do support this particular bill. We have nurse practitioners working in our program and providing services in isolated rural communities. They are, as your bill proposes, tied to full-time working physicians who provide proper medical back-

up and support. This bill would be of value to us in such small communities as Spirit Lake and Harrison.

If there is anything else we can do to support this bill, please let us know.

Sincerely,

LARRY M. BELMONT, Director.

Morehead Clinic, Morehead, Ky., March 19, 1977.

DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

Dear Mr. Harf: I am responding to a letter from Mr. Leahy regarding hearings before the Senate Rural Development Subcommittee regarding Medicare reimbursement of rural health clinic facilities. Mr. Leahy requested that I send you a statement of my opinions on this subject and I have enclosed a copy of the statement I recently gave before the House of Ways and Means Committee.

In addition, I should like to say that I believe reimbursement for services provided by nurse practitioners and physician assistants should be on the basis of the services rendered. Since physicians participate in the delivering of care, it would be impossible to accurately separate out the portion delivered by the assistant and the portion delivered by the physician. I believe reimbursement should be made to the clinic in which the clinicians work.

The National Board Exam recently devised for physician assistants would

seem to be me to an adequate certification process for these people.

I hope these opinions are of interest to you.

Yours truly,

RICHARD W. CARPENTER, M.D.

Enclosure.

STATEMENT OF RICHARD W. CARPENTER, M.D., MEMBER OF MOREHEAD (KY.) CLINIC

Chairman Rosterkowski and committee members, I am Dick Carpenter. I practice medicine in a multi-specialty group in Morehead, Ky., in rural Appalachia. We seek to deliver low cost but high quality medical care to the 100,000 people who live in the six counties that we serve. We have recruited sixteen doctors in six years, and have established two satellite clinics. The difficulties associated with this have been great. The cost of finding and establishing a doctor in our area is about \$25,000 per man.

It is more difficult and expensive to attract a doctor—and his wife—to

rural Appalachia than it is to a metropolitan area.

Our task is made much more difficult by the payment system Medicare and Medicaid employ. They pay lower rates to rural practitioners than to urban doctors. This penalizes those who wish to provide rural health care and tends to perpetuate the oversupply in cities and undersupply of practitioners in the country. I ask the committee to address this serious deterrent to providing rural health care.

Our group employs six physician extenders including a nurse practitioner, midwives, and physician assistants. Their performance has been good. They give their patients more time and attention and are accepted. They know their limits and do not exceed them, and therefore qualify as good health prac-

titioners.

We find them honest, kind and competent. When they practice alone in outlying clinics they should be supported by Medicare. Payment should be made to the clinics on the basis of service performed. In some sparsely populated areas the physician extender practicing alone provides a useful service where there would otherwise be none.

A model that I prefer is an extender and a physician working together to supply care. When they are together the extra knowledge physicians are assumed to acquire by their extra training becomes available to the extender.

The team composed of extender and physician combats the greatest foe a lone

country doctor faces which is social and professional lonliness.

It is lonely and discouraging when a patient is sick and a plan for recovery is not evident; a partner's advise helps. It is guilt producing when a practitioner does not have time to serve all those who need; a partner can help see

them. It is a lonely community role the physician and his family are asked to play. They are asked to be selfless and wise and almost without fault; a

partner makes this less lonely.

Yet another way to alleviate isolation and improve professional performance is to give the extender-physician a direct contact to secondary care such as multi-specialty group. In our experience this linkage speeds appropriate referral, improves flow of information about patients. This linkage tends to bring many of the resources of the multi-specialty group to the primary care site and I recommend that the community encourage such linkages.

> AUBURN CLINIC, Auburn, Nebr., March 28, 1977.

DAVID HARF. Officer of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: I am a physician practicing with three other family doctors in a town of 3,500 in southeast Nebraska. The legislation, such as S. 708 which would allow federal payment of physician assistants would allow the physician's assistants employed by our community to help the elderly of this community. Because of the load practice in this area, rest home visits to the elderly are not possible as often as we think would be desirable for their care. Also after the days patient list is compiled it is almost impossible to add on the number of extra patients who request to be seen for various illnesses each day. Physician's Assistants could, if they were allowed to see and care for people of medicare age, could help take up some slack in this area of patient care.

Payment for services provided to physician's assistants might be paid logically to the employing physician or to the physician's assistants themselves in a direct manner. In our state of Nebraska, all physician's assistants are required by law, to work under the direct supervision of a physician and are not able to work in another town away from his sponsoring physician. After consultation with the sponsoring physician the physician's assistant should be able to make referrals to other clinics or specialists and have some say in manage-

ment policies to aid patient care.

In the state of Nebraska physician's assistants are required to take a board examination in medicine to prove their ability to care for patients and we think this is right and proper and suggest that it would be advisable for other states to follow this lead.

Sincerely,

WENDELL FAIRBANKS, M.D.

CEDAR GROVE, N.C.

Mr. DICK CLARK, Chairman, Senate Rural Development Subcommittee, U.S. Senate Committee on Agriculture and Forestry, Washington, D.C.

DEAR MR. CLARK: I am Betty Compton—a Family Practitioner from Cedar Grove, North Carolina. I help to provide primary health care to the people of several small communities near my home through my practice at the Prospect Hill Community Health Center.

I appreciate the opportunity to lend my whole-hearted support to the changes in Medicare reimbursement policies as outlined in H.R. 2504. This legislation is, I believe, vital to the continuation of community clinics such as the Prospect Hill Clinic in our community and similar clinics throughout the country.

You have already read of the many community clinics such as ours that find themselves totally frustrated by the restraints of the existing Medicare regulations which make reimbursement for services rendered by physician extenders

contingent upon the physical presence of a physician.

The community of Prospect Hill is a typical North Carolina community in many respects. It differs a little, however, in its response to the medical needs of the people. It was the community's long search for a doctor to replace their General Practitioner for forty years (a search and plan that included building a small brick building to hopefully entice a doctor) that led the community to the UNC School of Medicine and ultimately to the door being opened.

Through the community's determination, the joint efforts of Dr. C. G. Pickard,

Jr. of the University of North Carolina School of Medicine, the Office of Eco-

nomic Opportunity and others committed to making health care available to the people, the clinic was opened in 1971 with two Family Nurse Practitioners on site and physicians from the UNC School of Medicine providing backup services

and regular consultation and supervision.

The plight of the community of Prospect Hill resembles that of other communities throughout the country. These communities do not wish to join the assembly lines at emergency rooms thirty miles away, nor do they relish waiting long hours in neighboring towns to see an already overworked physician who doesn't have the time nor energy to take on their medical care. What

they really want is health care brought to their community.

Physicians have not been nor are they now going to the small communities to practice. At the same time nurses like myself, living in these communities, find ourselves struggling with health care problems of the neighbors and friends who have medical needs beyond the skills of the nurse in the traditional role. I live in such a community where neighbors and friends simply had no where to go and no one to call when the medical crises occurred. Prior to my training as a Family Nurse Practitioner and the opening of the Prospect Hill Health Center, I was very familiar with the sick baby brought to my house at noon or even to the fields where we worked with a distraught family seeking medical advice. Often this request for help also involved an elderly relative or young working people themselves. The medical needs such as these would go unheeded if we assume the "doctors will save the people if you just give them time."

I totally agree with your position regarding the underserved areas of the United States. It is true that these communities cannot financially support a physician. Fatigue, overwork, lack of professional consultation and hospital accessibility plague the "country doc" as well as the reality that the days of fees being paid with a country ham, a few chickens, or a side of beef have

disappeared.

We now recognize that there is a way to provide quality care to these communities through physician extenders. This was given finite substance by the federal government several years ago when funding was made available to train Family Nurse Practitioners to provide primary care. It would now seem imperative that the Medicare legislation include the Family Nurse Practitioner in reimbursement policies.

1. How would legislation of this sort assist small communities of North

Carolina and the country?

I believe I have described in previous paragraphs the importance of this legislation to communities such as ours.

2. Just how many residents of the community would be Medicare eligible and

are they living at home?

In the ten mile radius of the Prospect Hill Community Health Center there are 8,000 or so residents. Age distribution in the area is difficult to determine since the radius extends into parts of four counties. According to data from the 1970 census our population is dominated by the age groups from 25-75 years. There are 199 males and 236 females in the community over 65 years of age,

and of these, a large number are widows who live alone.

Social change, stimulated by improved roads, improved education, and a multitude of other factors, has come to Prospect Hill as it has to the remainder of the state, but changes in the economy of tobacco farming have had a profound influence on the famly structures. Mechanization of farming has caused the departure of many young people to jobs in town. This migration of young people has left middle-aged and older people "caught on the farm caring for the home place." These older people were the land owners who have struggled to make their land a home for their children. Their ties to the home place and their land make it difficult for them to leave as they grow older. Their medical needs have increased as they grow older and their ability to travel to obtain this care has decreased.

3. In what manner should reimbursement be made for the services provided

by Family Nurse Practitioners and Physician Assistants?

The mechanism for reimbursement should be handled through the agency or corporation which is responsible for the governance and operation of the clinic. I also would recommend that physician reimbursement be handled through the same agency. The agency then would be responsible for salaries, fringe bene-

fits, and contractural arrangements for physician services (if the physician is

not a member of the corporation or agency).

Physician extender services should be reimbursed at the same rate customary for physician's services in the local area. This is not in any way meant to imply equal expertise. The medical expertise and skills of the physician far exceed those of the extender, but the physician provides back-up, supervision and consultation to the physician extender in providing services. The "equal fee" would help to defray the cost to the agency in providing for this essential physician supervision. (In North Carolina as in some other states, the physician back-up and supervision is part of the requirement for the practice of the extender).

4. What requirements should a clinic fulfill in terms of such factors as

physician participation?

A. The physician should either be employed by the agency or there should be formed contractural arrangements by the agency to provide physician back-up and supervision.

B. There should be an agreed upon set of standing orders for medical care.

C. Provision for periodic review of the extender's records by physicians must be made in order to: 1. insure compliance with standing orders. 2. assure quality of care by the physician extender. 3. modify standing orders to reflect current knowledge and therapeutic practice.

5. How would you arrange for referral system? There should be contractural referral arrangements both for hospital admissions and specialty care. (If the physician does not have admission privileges to the hospital, this should be resolved in some way to provide hospital accessibility.)

6. What would be management policies for clinic reimbursement?

There should be management policies to comply with federal guidelines. This should include personnel policies and fees consistent with those outlined for Medicare reimbursement.

7. What type of certification process should be used for the providers whose

services would be reimbursed under this legislation?

At this point and time, license to practice for both medicine and nursing are given by duly constituted licensing boards in each state. To monitor the practice of the etxender these two boards must recognize their combined responsibility for practice. Neither board should independently regulate the practice of an FNP; the boards of medicine are responsible as well for the performance of the PA. The basic requirement should be approval by appropriate licensing bodies for medicine and nursing in the state.

I do not agree with the ANA position that existing Nurse Practice Acts are adequate for the practice of an FNP. The practice of an FNP extends beyond the scope of nursing treatment and nursing management. Nurse Practitioners are de facto performing medical acts, and the medical practice component of their practice is legitimately the concern of the Board of Medicine.

I am concerned about the provision that FNP's would be eligible for medical reimbursement if they have been certified by The American Nurses Association.

I cannot speak for the National exam for PA's but I can address some concerns I have regarding the Certification Exam for Audit FNP's administered by the ANA. I understand it is the intent of this Certification Exam to assess

minimum competence.

On last area I would like to briefly address is the question of title for the physician extender. I've had some difficulty deciding what this new provider should be called. The two, ANA and AMA, differ greatly in their opinion. I find myself somewhat in the middle, prepared to say that nurses are not the only members of the team who care and are concerned, who teach and counsel - all of the things we feel are necessary for quality care. Physicians care too. Physicians and nurses need to recognize the nurse practitioner and physician's assistant roles as a blending of the two professions.

I would challenge both professional organizations to set aside their differences and to realize that the issues addressed in this legislation cannot be resolved

by either profession independently.

Sincerely,

STATEMENT OF MARIE CIRILLO, CLAIRFIELD, TENN.

Rural America became depleted of its people over the past 40 years, and according to most research and public opinion it has lost its best people. That is true only if we accept as best that which has become the established way. The established way is an urban way, and rural people have very little right to dignity, self respect and opportunity to engage in community developments. If they can't afford a shopping mall there seems to be nothing else worth aspiring to. If they can't have a Saks Fifth Avenue where can they get "class"? If they can't have a theatre, a bank or a hospital, the popular opinion seems to be that it is because the smart people have all left the area. The truth of the matter is that the "big is better" syndrome has been supported by government policies and subsidies. Rural areas have lacked the necessary support system to grow in a style fitting the "small is beautiful" concept. The concern about the reimbursement for Nurse Practitioners in rural clinics is a good example of a rural need that needs government support for its appropriate health delivery system.

In 1945 the coal mining community of Clairfield had 12,000 residents. In 1967 it had 1,200. They were the old and the very young - the welfare recipients and those on social security, retirement and AFDC. It was in this community that a few citizens decided that they desperately needed and really wanted some health services in the valley. Perhaps they got the idea because they once had a clinic supported by the mining companies and then one that was run on an experimental basis by the state. Both had been gone for years and the old were getting sicker while the young were getting no care.

In 1967 the local citizens of Clairfield began to organize themselves to get

some health service. It soon became apparent that they needed to form a local health organization. With no doctor or lawyer the citizens formed a group, obtained their tax exempt status, rented and renovated an abandoned schoolhouse which had gone back into the hands of the foreign land company when it ceased functioning as a school, and later found a small plot of land (also a major feat in a community that has 80% of its land tied up by one absentee land company), and constructed their own clinic with only \$5000 of support from county revenue funds. It was this group that recruited their first doctors, nurses and dentists who, for the most part were volunteers. They hired the first full time nurse. It was this group that eventually disassociated themselves from the local OEO program since they felt the help was not worth the constraints put on them. It was people with experience on the clinic board who eventually resigned from that duty to move to what they considered more important — a safe water system. Being unsuccessful in obtaining help in putting in a water system, the community settled for a public water spigot that cost \$6,500. What I am trying to say is there has been no lack of ingenuity or hard work from within the community to meet their most pressing health needs.

It was this kind of local determination that brought results and that inspired other communities of East Tennessee, E. Ky. and S. W. Va. to organize for health care in their community. It was this kind of people who inspired Vanderbilt students, other nurses, doctors and dentists to be supportive to such genuine community effort. It was the citizens of Frakes, Petros, Stinking Creek, Briceville, Stoney Fork and a host of other communities that provided the organizational base out of which a facility, a financial arrangement, and a network of medical personnel began to develop. It was eventually the Regional Medical Program in Tennessee, The University of Ky., and the Appalachian Regional Commission that began to support these community efforts.

The government and medical personnel began to insert their ideas about a medical delivery system. Their ideas were greatly influenced by the practical and financial realities of the medical system. The clinics provided good experimental stations for these people, and the development of a role for the Nurse Practitioner was perhaps the one experiment that offers most for the local community clinics. This personnel cuts costs, provides constant professional service at the clinic, becomes the key person to whom doctors relate and certainly has the potential (and in some cases it was the reality) and capacity to relate to

the local community board. Some of the clinics lived the life span of the governments experimental support and closed their doors in 1976. Others are in their last year. The experiment with the Physician Extenders has not lasted long enough for the interest of government and medical personnel to subside sufficiently for community groups to build their true relationship with this key medical staff. Since there is general good feeling about the Physician Extender being the real key to community initiated efforts for better health service, it is important that it

continue and that a plan for reimbursement be established.

I realize my interest in the Physician Extender goes beyond keeping rural clinics opened to encouraging the development of locally controlled primary health care centers. As taxpayers monies go into services, the need and right for citizens to say something about that service must be facilitated by government. The problems our clinics are faced with provide a very specific example of how our national orientation to urban methods, plans, procedures, financing and training has left our nation with a real dirth of leadership capable of handling the rural scene. The re-emergence of rural life as part of the American scene is going to challenge and make demands of Congress. Very new and very different approaches and solutions will challenge all of us to reconsider old formulas for success. The S. 708 bill represents this new direction.

It is my firm belief that the training, orientation, mental attitude of doctors today could never provide the initiative needed to deliver health care in Rural America. I also believe it would be quite unjust to expect Rural America to wait 10 years to see a new breed of doctors, when local citizens were beginning to demonstrate some capability ten years ago. In areas as deprived as Clairfield we could expect neither doctors or nurses to initiate the organizational base for health care delivery. They know before they start that they cannot make it work financially. Local people organize on the basis of real need. Now they are coming to the government for assistance. Obviously what is needed as government gets into the act is a partnership with the people. I believe the most positive link on which to build this partnership is through a sustained support to the Physician Extenders.

The physician extender could be the critical link between the economic and

service tensions that exist in the medical delivery system.

The physician extender could be the critical link between the medical-community tension existing as efforts are made to extend the health services into rural areas.

The physician extender could be the critical link between the governmentcitizen tension existing in a service needing public support but where lobbying

efforts of the medical establishment give their interests great visibility.

Obviously it is more than the survival of the physician extender that will bring all these factions into relationship. But the physician extender, if properly trained and oriented and if allowed to become a stable person in the rural primary health care clinic has much potential for making a major contribution to the needs as perceived by local citizens within their community.

I therefore strongly urge you to take action on S. 708.

VALENTINE CLINIC ASSOCIATION, Valentine, Nebr., March 23, 1977.

Senator DICK CLARK, 404 Russell Bldg., Washington, D.C.

Dear Senator Clark: We are writing to offer testimony in behalf of S. 708; a bill to authorize Medicare reimbursement for services provided by physician

extenders in rural areas.

Our clinic in Valentine, Nebr. serves a large area of the "Sandhills" in north central Nebraska. We employ a Physician's Assistant and have found his services to be invaluable in treating the large population we serve. The use of the P.A. has enabled us to see more patients with shorter waiting time for appointments. In addition our P.A. covers many minor "after hours" emergencies and assists in delivering hospital and nursing home care. This not only allows us to better serve our patients but to do so at less "personal cost" (i.e. long hours, little family time, etc).

We also utilize a P.A. in a satellite clinic in Mission, S.D., 35 miles from Valentine. This second P.A. means increased availability of services for

patients from the outlying areas we serve.

We are very pleased with the work of our P.A.'s and patient acceptance has

been outstanding.

However, as you know we are unable to be reimbursed for Medicare covered services provided by our P.A.'s. This has caused problems in the local setting

and has caused us to consider closing our Satellite clinic since it currently operates at a loss. It would surely be detrimental to area health care if we had to curtail or discontinue the services provided by our P.A.'s. Without Medicare reimbursement provisions this is a very real possibility. Therefore, we support S. 708.

We believe your formula of cost reimbursement is reasonable considering the

rising cost of health care.

As far as requirements for reimbursement. We wholeheartedly support your requirement for proper certification of P.A.'s. This is a must to maintain high quality health care. We also strongly support the requirements for regular physician review, medical records, and for procedures for prompt referral to hospitals. We support with reservation the requirement on "written policies to govern the management of the clinic and all the services it provides". As I'm sure you know the problems encountered in a rural clinic are quite varied. I seriously doubt that we could ever implement written plans and protocols for all or even most of these problems. We would certainly be in favor of written policies for the more common and/or more serious (i.e. life threatening) problems. These policies cannot cover every contingency. However, you must remember that these "properly certified" P.A.'s are highly trained and are capable of making sound judgements in the *initial* assessment of problems not covered in writing. Requirements which are too rectrictive in this area may very well tie the "extra pair of hands" which P.A.'s represent.

Sincerely,

J. E. FARNER, M.D., President, Valentine Clinic Association.

EMMET COUNTY BOARD OF SUPERVISORS, Estherville, Iowa, March 21, 1977.

Re S. 708.

Mr. DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: My name is Jim Peterson, not James. I do not like James. It would be very gratifying to see S. 708 become law. Such a bill would pro-

vide, in the rural areas, a desperately needed service.

I retired from the Coast Guard some years ago and one of my tours of duty after the war was in the South Pacific, the Marshal and Gilbert Islands, providing logistic support to Coast Guard Loran stations. On our ship we had a 2nd class pharmacists mate, and I recall on our visits to the islands how the natives, sometimes a hundred or more, would line up for our 'medicine man' to receive minimal medical treatment. He would check hearts, blood pressure, eyes, ears, hearing, throats, open sores, temperatures and so on. And only when he deemed it necessary would we transport a patient to the hospital at Kwajalien. And there were many instances, during the war, WWII and the later ones, where hospital corpsmen performed surgery, and successfully too, by the way. I am not advocating surgery by these medical assistants in rural areas but only to point out that they are capable of providing a valuable and much needed service, and in time of extreme emergencies their services can be extended. Not only would they provide a needed service but they would also fill a yearning psychological need . . . someone with some medical knowledge available. I am not, here, comparing our rural residents with the natives of the south pacific islands — but only in so far as they are also human beings.

Payment could be made through county offices: approved by the county nurse, and/or the county welfare office, submitted to the county auditor and approved by the board of supervisors. I think there should be some sort of a ceiling on the fees, set by a responsible board, because if there isn't the chislers will run

away with it as they have with medicare/medicaid already.

I believe the clinic should certify the practitioners, and/or they should pass

an examination much like the armed forces medics do.

I hope this has been of some help. It is a hurried summary to a complex situation. You didn't give me much time. I received your letter the 14th. One was dated the 4th and one the 7th. And you wanted an answer by the 25th. Good Luck!

Sincerely,

TOWNSHEND, Vt., March 21, 1977.

Hon. Patrick J. Leahy,

232 Russell Bldg., Washington, D.C.

DEAR SENATOR LEAHY: The enclosed statement represents my personal views on S. 708, a bill to amend Title XVIII of the Social Security Act to provide

payment for rural health clinic services.

I have been a member of the board of trustees of Health-Care and Rehabilitation Services of Southeastern Vermont, Inc., since its establishment in 1968, and was it first president. However, the material relating to S. 708 was not received until March 18, and with written comments in lieu of personal testimony requested by March 25, it was not possible to submit this statement to the board for formal approval, although it expresses the views of individual board members.

This opportunity to testify in writing in favor of S. 708 is very much ap-

preciated.

Sincerely,

BERNARD W. SCHOLZ.

COMMENTS ON S. 708

BACKGROUND

Health-Care and Rehabilitation Services of Southeastern Vermont, Inc., is a private voluntary organization dedicated to the promotion of the availability of comprehensive health care and rehabilitation services throughout Windham and Windsor Counties, Vermont. Incorporated in 1968, it is a membership organization, paying its expenses entirely out of voluntary membership contributions and donations, and operating entirely with volunteer staff.

In 1969, the agency (HCRS) sponsored the establishment of a project for the identification, diagnosis and treatment of developmental disabilities in preschool children. In 1972 this project was incorporated as an independent agency

under the name Winston L. Prouty Center for Child Development.

In 1972, HCRS sponsored the establishment of a project for the provision of visiting nursing service, visiting homemaker service, and visiting physiotherapy service in five towns of the West River Valley in Windham County. In December of 1972 this project was incorporated as an independent agency under the title The Valley Health Council, Inc.

Also in 1972, HCRS sponsored the establishment of a project for the provision of comprehensive mental health services on a regional basis throughout Windham and Windsor Counties through the merger of two small existing mental health agencies with limited programs. On July 1, 1975, this project became operative as Mental Health Services of Southeastern Vermont, Inc.

HCRS is concerned about the fact that these three agencies are not functioning to their full potential due to the current restrictions on eligibility for payments under Title XVIII of the Social Security Act. HCRS is even more concerned about the inadequacy of available comprehensive health care in its service area. Statistically, there appears to be adequate physician coverage for the citizens of Vermont. Actually, however, there is a high concentration of medical professionals around the larger medical facilities, especially the University of Vermont, while certain areas of the State are without any medical care provisions.

There are several rural health clinics in Southeastern Vermont, such as Cavendish, Chester, Londonderry, and Wilmington. In the West River Valley, on the other hand, there is only a small private hospital with superannuated staff and very limited facilities (according to a survey undertaken and published by the Connecticut Valley Health Compact, Inc., in 1969). Younger physicians have tried to become established to serve the citizens of the five towns in the Valley, but found the workload excessive, the remuneration in-

adequate, and left.

THE POTENTIAL IMPACT OF S. 708

1. HCRS is anxious to establish an H.M.O.-type rural health clinic in the West River Valley, and at the same time stimulate the integration of existing clinics, nursing and homemaker services, and mental health services into a comprehensive health-care network, covering its entire service area. If physician extenders could be located strategically in the service area, primary care would become accessible and available to persons currently out of reach of

existing facilities, and physicians would be attached to central clinic locations where referral to, or backup by specialists from not-too-distant medical centers would be available.

2. Present tentative plans call for the employment of physicians and physician extenders on a fixed salary, with reimbursement being made to the individual rural health clinics, unless these were consolidated in a regional or-

ganization, in which case reimbursement would be made to the latter.

3. The policies and procedures established under the Community Mental Health Centers Act of 1975, as amended, appear readily adaptable to rural health clinics insofar as physician participation, arrangements for referral, and management policies are concerned, for the purpose of qualification for reimbursement.

4. Current requirements under Vermont statutes appear adequate for the certification of providers of reimbursable services under the proposed legis-

lation.

The proposed amendment of Title XVIII of the Social Security Act, though not a panacea by any means, would be a giant step in the direction toward more rational health care in rural areas.

FAIRMONT, W. VA., March 24, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

Senators Clark and Leahy and members of the Rural Development Subcommittee, it is a privilege and honor to have been given the opportunity to address the issue of Medicare Reimbursement for physician extenders. I believe what I have to say is pertinent to the concerns addressed in S. 708 and com-

parable bills in the House of Representatives.

I am a resident of West Virginia, the only state which lies entirely within the region of Appalachia. Most of our state falls within government definitions of rural. A high percentage of our population are senior citizens. According to 1970 cenus data, we have by far the highest percentage of blacks and other non-white residents over the age 65. Some 40 of our 55 counties are classified as "medically underserved areas"!

I serve on the Board of Directors of a private non-profit corporation which operates three clinics: one in the city of Fairmont and two rural satellites. I have served over six years on the Comprehensive Health Planning Agency Board which covered six or eight counties, most more rural than my own. I also chair the West Virginia Committee for the Health Security Act (S. 3).

According to a study done by a team of persons at West Virginia University and printed in various places including Senate and House hearings, West Virginia has consistently been 51st in per capita Medicare reimbursement. Previously we have cited that data chiefly to substantiate our need for personnel and health services. However our state and its medical licensing board has been restrictive toward the use of Physician Assistants and other physician extenders apart from the presence of a doctor. S. 708 would unquestionably aid our state in liberalizing its restrictive attitude so that physician extenders could be more widely and efficiently and properly used.

Furthermore, S. 708 would bring to West Virginia a more equitable share of the Medicare tax dollar. With a high percentage of over 65 in our population, it is clearly discriminatory that we should rank even near the bottom of Medicare reimbursement let alone 51st year after year. This is an inequity

which must end.

On the question of the manner of reimbursement, I find myself recommending a position which on the surface seems to contradict the general viewpoint of congressional and health economists today. Indeed, it even seems to contradict my own better judgment. I recommend the following approach only because it makes the best sense in the present system of health care delivery and financing. I hasten to add that it can only be temporary: only a national program of the scope and quality of S. 3, the Health Security Act, can deal responsibly with the issue of both cost and quality control.

I recommend that for small rural clinics such as those throughout Appalachia that reimbursement be on the present basis of a "reasonable and a

customary fee" rather than on a cost basis.

Mr. James Burnell, Controller for the Monongahela Valley Association of Health Centers, Inc., and a consultant to the Robert Wood Johnson Foundation on establishing fiscal systems for developing rural clinics makes an excel-

lent case against the cost basis.

Mr. Burnell points out that in clinics he visited, Administrators were college educated but did not have a great deal of expertise in fiscal matters. Furthermore, these clinics do not have the staff nor the finances to operate a sophisticated financial system. It is therefore difficult to establish reliable financial reporting for their entire operations let alone the more detailed reporting which cost reimbursement would demand. In short, it's very difficult for them to break out of the cost of various services such as laboratory pharmacy, X-ray, pediatrics, etc. They simply do not have the ability to do a further analysis of cost which are strictly legitimate for Medicare reimbursement. To ask them to further delineate the portions of their costs related to Medicare is to ask something which they simply cannot do. It would therefore be selfdefeating to base reimbursement on cost.

Perhaps in order to prevent the abuse of the customary fee base which has been common to Medicare, the Congress should set a percentage of an established fee for a physician visit as the standard or allowable fee for a physician

extender.

One of the widespread criticism of Medicare has been its paperwork. This is especially problematic for small clinics. Rather than being rewarded for their low administrative costs, they are often victimized because Medicare will not pay for physician extenders and they are heavily audited by HEW auditors whose time and results would be far more profitable at large agencies or institutions.

A final word on reimbursement: Ann Suter Ford in the *Physician Assistant: A National and Local Analysis* (1975) p. 127 says: "In order to maximize efficiency in the actual use of the Nurse Practitioner and the Physician Assistant as an added incentive to widely employ these new professionals, problems or reimbursement must be resolved as soon as possible. If Physician Assistant and Nurse Practitioner services are not eligible for third party reimbursement, the entire costs of their employment would be necessarily assumed by their employers; this would result in higher costs to the consumer as well as possibly encouraging the maldistribution of these new professionals. For example, PA's and NP's may find employment opportunities primarily in large urban financially lucrative practice; such a distribution would do little to correct the

specialty and geographic maldistribution problems. . ."

In regard to the effect of primary, care institutions such as rural practice clinics which use PA's and NP's, I refer the committee to the results of a study announced by the Appalachian Regional Commission on February 23, 1977. I understand the full report of this study has just recently become available from the Appalachian Regional Commission. The study raised a question, "Is community wide hospitalization noticeably reduced by introduction of a primary health care center?" Studies by John Runyan, Jr., MD, of the Nurse Practitioner Staffed Diabetes Coronary Disease Clinics in Memphis, indicate that hospitalization is reduced 50 to 70% among the elderly. In a study of the elderly population served by the Frontier Nursing Service, Gertrude Issacs showed a similar reduction in hospitalization in comparison to a similar population not served by Frontier Nursing Service. Karen Davis found the same for Neighborhood Health Centers. If these results are valid, then Medicare and other third party reimbursement for physician extenders would be a major contribution to cost control in the spiraling health care costs and inflation in this country.

The provision of S. 708 appear to me to be reasonable requirements in order for a clinic to qualify for reimbursement. Adequate physician supervision and availability for consultation and referral is essential. Adequate training and certification standards for the physician extenders is equally important. But if the concepts of physician extension is to be meaningful, these persons must be allowed and encouraged to function to the maximum of their abilities without the immediate presence of the physician. The failure to provide Medicare reimbursement has contributed to this inefficient use of health providers

and its consequent waste of dollars and personnel.

One final word: The United States must adopt a Comprehensive National Health Plan which will draw together the positive benefits of America's health delivery system and eliminate the massive flaws in the present system. The only legislation before the Congress which approaches the matter seriously and

comprehensively and which incorporates personnel incentives, primary and preventive care, and both quality and cost control is S. 3, The Health Security Act. This must be moved to the top of the Congressional Agenda and enacted by this Congress.

Thank you very much again for this opportunity.

Rev. RICHARD BOWYER.

STATEMENT OF GERTRUDE ISAACS, D.N. Sc., FRONTIER NURSING SERVICE, HYDEN, KY.

BENEFITS OF THE RURAL HEALTH CLINIC BILL

The new rural health clinic bill S. 708, introduced by Senator Clark, will be a major boom for the aged of rural America, and the taxpayer's pocketbook. It will help make primary health care more readily available to the senior citizen in rural areas, and lessen the need for costly medical care that is con-

centrated largely in the bigger metropolitan centers.

Primary health care, which is almost non-existent in rural areas is needed for the day-to-day mangement of the health problems that commonly afflict the aged; and it should be provided in the community in which they live. This is particularly important in rural areas, such as Appalachia, where transportation is still a major problem. Studies 12 indicate that few people in cities or rural areas will travel further than five miles or twenty minutes travel distance for primary care until the problem becomes acute. Generally the more acute the problem, the further they will travel; and the greater the cost to the family and the institution. The cost of medical care is therefore usually much greater for the rural citizen than it is for his urban counterpart; if he bothers to seek it. Frequently, he will not, because he has neither the strength nor the means, and it is not designed to meet his most urgent needs. The rural elderly are therefore less likely to seek care when ill.

Today's health care system is designed primarily for the medical care of acute problems. It is not designed for the care and management of chronic illnesses and disabilities, or other minor ailments, which are common among the aged. It is not designed to promote preventive care—proper diet, activities, personal care and housing—to retain health and reduce the incidence of chronic illness and disability; or to provide maintenance care after illness or disability occur, to avoid further deterioration of health and ability to function.

All three—preventive, acute and maintenance care—are necessary, but they must be coordinated and properly balanced, if they are to meet the health needs of our citizens in a manner that society can afford. The rural health

clinic can help fill the gap, if a means can be found to finance them.

The Frontier Nursing Service has found that the sixty-five and over age group will seek 70-78.5% of their care through these rural health clinics, which are directed by primary care nurses, if such clinics are available to them. They will seek 65-85% of their care for chronic conditions and up to 65% of their care for acute illnesses from these clinics. This system, if it includes home health care services, will help reduce hospitalization for acute care of the 65 and over age group by 70%. It will do the same for the diabetic patient. It is a major convenience for the senior citizen, the chronically ill or disabled, and their families.

A study³ of 230 diabetic patients served by the FNS in 1974 showed that hospitalization was reduced by 70% through this system. The patients were an average of eight years older, at the time of hospitalization, and they had fewer diabetic related complications. The average cost was \$309 per diabetic per year. This included hospital, outpatient home health care, drugs, x-ray and laboratory costs. Only 14% of the outpatient care was provided by the physician. The national average cost per diabetic for hospitalization alone at \$118 a day, was \$627 per year. Dr. John W. Runyorn,⁴ of Memphis, Tennessee, reports similar findings in his chronic health care program. Sufficient findings of the effectiveness of rural health clinics are currently available to warrant their support without further delay.

The table below shows the proportion of services sought through the rural health clinics, that were within five miles of the area served; and the proportion of care sought from the primary care medical center that was within 5-30 miles of these rural health clinics. The rural health clinics were staffed by primary care nurses and provided home health services. The primary care medical center, which is staffed by physicians and nurses, provided the neces-

sary medical care, the medical assistance, consultant and referral services, as well as hospital care and related health services. All are operated under the same administration. The table shows the ten most common diagnostic categories of illnesses and disabilities for which care was sought. It includes all age groups. It does not include the preventive care services provided. The agency served a population of approximately 16,000.

PROPORTION OF OUTPATIENT VISITS FOR THE 10 MOST COMMON CHRONIC AND ACUTE CONDITIONS RANKED ACCORDING TO THE CLINIC SITE PROVIDING MANAGEMENT AT THE FRONTIER NURSING SERVICE, JANUARY TO AUGUST 1974

Rank	Condition	Rural health clinics		Primary care medical center	
		Percent	Number	Percent	Number
1	Heart	85	2, 236	15	388
2	Rheumatism and arthritis	81	838	19	206
3	High blood pressure and stroke	79	2, 180	21	584
4	Diahetes	78	1, 105	22	323
5	Chronic respiratory	74	1, 110	26	373
6	Iron deficiency—anemias	66	367	34	187
7	Acute respiratory	65	1, 572	35	870
8	Kidney and urinary	64	983	36	556
9	Upper respiratory	58	2, 386	42	
10	Gastro intestinal	54	699	46	1, 733 593

The more acute or critical the illness the more apt the family was to go to the Medical Clinic. After management of the acute phase of the illness the patient returned to the rural health clinic for continuing care, with the plan of

treatment established by the physician.

This system permits the nurse to become familiar with the family in its environs, and the community and its resources. It helps make the care, the teaching and the counseling more relevant to the problem, and permits the family to participate more fully in their own care. It permits the family to make their own choice and be less dependent on medical care; and it provides the mechanism for close coordination between the health clinic, the medical services and the hospital. The major problem has been the financial reimbursement system.

RECOMMENDATIONS FOR A REIMBURSEMENT SYSTEM

The Frontier Nursing Service heartily supports the principle of reimbursing the rural health clinic for the services provided by primary care nurses, and not limiting reimbursement to practitioners credentialed as physicians. The current reimbursement system must be modified and extended to make it practicable for rural health clinics. The present fee-for-service billing mechanism is too complex, too rigid and too costly. It encourages quantity rather than quality; and puts the emphasis on treatment, rather than prevention and health maintenance care. It encourages high utilization of medical and health manpower, and increases the use of modern technology, often unnecessarily. It creates an inordinate amount of bookwork, that requires sophisticated auditing and bookkeeping procedures as well as clerical assistance. All are very difficult to acquire in rural areas. It discriminates against rural areas; the more rural the area, the greater the discrimination. In 1973-74, our county which is in a very isolated rural area received an average of \$82 medical assistance per eligible recipient and the rest of the State received an average of \$229 per eligible recipient. This does not begin to meet the costs expended.

For these reasons, the FNS strongly recommends the exploration of capitations fees to provide reasonable and equitable reimbursement for rural health clinics, based on the services provided according to costs. At today's cost, rural health clinics in the area could be operated for a capitation fee of \$95 per year or at \$8.00 per month per individual registered for care. If the clinic provides home health services, capitations fees for the sixty-five and over, and for the chronically ill and disabled now eligible for Medicare, the annual fee

would be \$155 per year or \$13.00 per month.

These fees would provide for the following revenues and operating costs for a community of 500 in which 10% of the population would be 65 years old and over and therefore eligible for Medicare. It does not include medical assistance, consultation or referral fees, which the physician would continue to bill for separately until such a time as alternative means for billing are established.

Revenues from capitation fees

 $450 \times \$95.00 = \$42, 750.00$ $50 \times \$155.00 = 7, 750.00$

Total____50, 500. 00

Operating budget for rural health clinic

Salary for 1 family nurseSalary for 1 licensed practical nurse (to assist with home health care and clinic services)	7, 000. 00
Salary for clerical assistant	5, 000. 00
Total salaries Fringe benefits (at 13 pct.)	27, 000. 00 3, 500. 00
Total personnel Maintenance and operation of rural clinic (this includes rent, equip-	30, 500. 00
ment, supplies, transportation, audits, etc.)	20, 000. 00
Total costs	50, 500. 00

This presupposes that rural health clinics would not be established to serve the senior citizens only, but that they would provide total family care. Coordinated services are more practical and cost conserving, and less discrima-

tory than specialty programs.

A mechanism for appropriate review and audit of costs would need to be established. A monthly statement of services provided together with costs, and expenditures should be submitted to provide a base for monthly reimbursement. An annual audit should be conducted to monitor costs on the basis of services provided, to assure reasonable and equitable reimbursement for costs, to review cost overrun created by care of catastrophic illnesses, such as kidney dialysis; and to provide a base for annual budget planning, which would take into account the increased costs of health care and related costs. Until reimbursement is extended to the total family, only the Medicare patients would be covered.

RECOMMENDED REQUIREMENTS FOR MONITORING QUALITY OF CARE

All rural health clinics should be certified or licensed through a State Regulatory Body, such as the Kentucky Primary Care Center Licensure System. Such health clinics might be operated under the direct management of a Primary Care Center; or they might be operated by a small rural community and have contractural arrangements with a Primary Care Center or other medical clinics and hospitals for medical services and hospital care.

All rural health clinics should be required to meet minimum standards of care as established by the state regulatory body to qualify for reimbursement, or such standards as may be established by the Federal Government, if the

state has no regulatory body.

An annual on-site survey should be conducted to assure the maintenance of minimum standards. These surveys should include review of:

(1) Primary care services provided through records and reports.

(2) Qualifications of staff.

(3) Arrangements for medical assistance, consultation and referral, and related back-up, e.g. hospitalization, dental care, social services, etc.

(4) Adequacy and safety of the facilities and the equipment.

(5) Management policies and operations.

(6) Annual audit of revenues and expenditures in relation to services provided. All deficiencies should be noted and reported to the reimbursement agency.

Each agency should be required to have its own arrangements for a monthly audit or review conducted by a separate team, to assure quality of care. This team should include a minimum of one physician to review medical care, one nurse to review nursing service, adn one social worker to review social services. The team should do a random review or audit of a minimum of 1%, or

five patient records for each provider to 1) assure reasonable quality of care, according to established protocol; 2) to provide opportunity for joint (team and provider) assessment of the services rendered on the basis of need; and 3) to explore other options and alternatives for the improvement of services provided. Written reports of these audits should be available to other review teams.

The Federal Government should be responsible for establishing guidelines and criteria for reimbursement. Arbitration Boards should be available for appeal

for all involved at local, state, and federal levels.

CERTIFICATION OF PRIMARY HEALTH CARE PROVIDERS

All primary health practitioners should be required to have completed a formal program of study that is recognized and/or accredited by the provider's Professional Organization and each should be certified as a primary health practitioner through National Examinations established by their respective Professional Organizations. For example, family/adult nurse practitioners should be certified through the American Nurses Association; and physician's assistants through the National Commission on Certification of Physician's Assistants. All practitioners should be licensed/authorized within the State in which they practice.

TITLE OF HEALTH PRACTITIONERS

This is an issue that should not interfere with the passage of the bill. No one likes to be called an extender, and each would prefer to be called by his/ her respective title. Family nursing is a new specialty in nursing, as family medicine is a new specialty in medicine.

The important thing is that we learn to work together for the common good

of all.

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STATEMENT OF DR. AARON SHIRLEY, JACKSON-HINDS COMPREHENSIVE HEALTH CENTER, JACKSON, MISS.

Senator Clark, Senator Leahy and other members of the committee, thank you for allowing me to testify. I am the Project Director of the Jackson-Hinds Comprehensive Health Care Center in Jackson, Mississippi. Our health center operates under the Department of Health, Education and Welfare's Community Health Center Program and offers a wide range of comprehensive health and medical services to residents of the City of Jackson and surrounding Hinds County. We also support a satellite facility in Utica, Mississippi, which serves

a completely rural population.

Large numbers of people living in the South have historically been denied access into the traditional medical services system. Poverty, race, rural residence and hostile environmental conditions have proved powerful barriers. Over 10 million people, or 20 percent, of all those living in the eleven states South have incomes below federally defined poverty levels. Twenty percent of the South's population in non-white; the figure is 37.2 for Mississippi. In four Deep South states over half of the people live in rural areas; in five states, over a third. In nine of the Southern states, the percentages of dwellings lacking some or all plumbing facilities is twice the national average. Each of these factors

is interrelated and the combination of these barriers has not a definite impact on health levels within the region. This is especially true of minorities and the

poor living in rural and inner city areas.

A rural health research project, undertaken for the Southern Regional Council's Task Force on Southern Rural Development deals with many of these issues. The project's final report is due to be released this summer, but the preliminary summary report, Rural Health Care in the South by Karen Davis and Ray Marshall, summarizes some important findings: "Leading indicators of health status reveal that rural southerners have poorer health levels than other citizens and therefore a greater need for health services. Infant and general morality rates in the nonmetropolitan South are much higher than in other areas. General death rates were 22 percent higher in the non metro South than nationally. Infant mortality rates are 65 percent higher among nonmetropolitan Black southerners than among whites. General and infant mortality rates are higher for both races in counties with a greater incidence of poverty. The report also revealed that rural southerners have a greater incidence of accidents, more days of disability and more chronic conditions than do citizens in other regions."

Despite proportionately greater health needs, rural southerners have access to fewer health and medical care resources. Primary care physicians and other health professionals are less available on a per capita basis in the non-metropolitan South. Physician population ratios are particularly low in smaller nonmetropolitan counties with high poverty rates. Although rural southerners have a higher incidence of health problems, they receive fewer medical and

dental services.

Rural residents are less likely to be covered by private health insurance plans, and the plans they do have are less comprehensive that those of urban residents. Public program have not responded by filling the gap in this private health insurance coverage. Dr. Karen Davis of the Brookings Institution has done extensive research in this area. She reports that public programs have less extensive benefit coverage in the nonmetropolitan South than in other areas. Half of all poor children in the nation are covered by Medicaid. In the Southern states of Alabama, Arkansas, Louisiana, Mississippi, South Carolina and Texas, only one poor child in ten receives Medicaid benefits. Dr. Davis notes that few rural families receive Medicaid services because, in the South, the program provides benefits largely to one-parent families while most rural families are two-parent families with low incomes from agriculture, small manufacturing, or public service jobs. Nationally, average Medicaid expenditures per poor child in nonmetropolitan areas is \$5 compared with \$76 in central city areas. Although the Medicare program has been responsible for removing the financial barriers to health services access for many elderly southerners, program expenditures in the South do not reflect the greater need for health services. Average Medical expenditures on physician services per person enrolled is \$73 in the nonmetropolitan South, compared with \$100 nationally.

Clearly, the nation's health care system—and various publicaly supported programs designed to alleviate the barriers inherent in that system—have not responded adequately to the needs of poor and minority consumers. Poverty—and all that living without an adequate income implies—is still the single most influential factor affecting health status. Race is also an important factor. Discriminatory practices among health providers, particularly in rural areas, such as separate waiting rooms and different hours, are common. Black patients also receive poorer quality care from some rural providers. This is especially important, since Black consumers have few, if any options, among

medical care providers in many rural settings.

In order to make the nation's health delivery system respond to the health and medical needs of all southerners, widespread changes must be made in the nature and content of rural practice. These changes must be complemented by constructive changes in the financing of health care service. Public policy must recognize the relationship between these areas and develop effective alternatives to deal with the entire range of related issues. It is meaningless, for example, to provide a financing mechanism for the payment of physician services without also attacking the problems of physician availability and access to health and medical services.

There are serious faults in a public policy approach that allows a nurse practitioner clinic, operating in a rural area unable to attract a full-time physician, to face continuous financial hardship because the nurse practitioner provider can only be reimbursed for services when the physician is physically

present.

A number of alternative and innovative approaches to the delivery of health care services are currently being tried throughout the region. The data on these models is incomplete at this time, but based on the experiences of the Rural Health Project, the following components should be considered as part of any comprehensive attempt to deal with the delivery of health services in rural areas.

Rural health practices should be especially concerned with environmental health and preventive medicine. It is not at all clear that private medical professionals can or will provide the leadership for environmental health and preventive medicine. Establishing nonprofit corporations with community representation on boards of directors should cause medical practices to be concerned with environmental health problems such as impure water supplies,

substandard housing, inadequate waste disposal systems, etc.

Community outreach programs and transportation facilities improve access to medical care, but these services increase the cost of providing health care. Since it is desirable to provide environmental and preventive health services as well as services facilitating access to health care, these costs should be borne by the public. Expenditures for environmental and preventive health make the immediate cost of medical care seem higher than would be the case if only traditional medical care were provided, but these expenditures would probably be very cost-effective in the long run.

An essential component of a model rural health program is *comprehensive* ambulatory care. Special attention should be given to meeting the dental care needs of rural people. In many ways dental care is relatively worse in rural areas than medical care. Mental health also appears to be a significant problem in many rural areas. Services of qualified mental health professionals

should be a key part of rural health delivery.

Rural areas have a much higher proportion of elderly people, and the incidence of chronic conditions and confinement to bed is much greater in the rural South than other areas. Emphasis upon home health services which provide qualified nursing care to homebound elderly is important in the rural South.

Attention to the nutritional needs of rural Southerners should also be a part of the health system. Participation in federal nutrition programs and nu-

trittional counseling should be encouraged.

Because of low educational levels, many rural residents are unfamiliar with good health habits. Effective patient health education, supplemental with visual aides where appropriate, should be a part of rural health care.

Since preventive care has long been neglected in rural areas, special emphasis should be given to well baby care, immunization, family planning services by

choice, cancer screening, and prenatal services.

A comprehensive approach to rural health care should also consider the following delivery mechanisms:

Emphasia an annual suis.

Emphasis on group practice where needed to counter professional isolationism and overwork.

Emphasis on nurse practitioner clinics with back-up part time physician support for smaller communities which cannot support or attract groups of physicians.

Legal support and technical assistance should be given to promote the ef-

fective use of non-physician health professionals.

Ideally, rural health care should be part of a system which extends care into remote areas through satellite facilities which are affiliated with hospitals, laboratories and other specialists in the area.

Provisions should be made for the continuing education of health profes-

sional involved in rural practice.

Current federal and federal/state health programs have proved to be of limited assistance to rural Southerners. Changes in public financing policies are necessary to correct the imbalances present in current policies:

Coverage of all people regardless of family composition, eligibility for welfare, employment status, or other conditions. No direct patient charges should

apply to low income persons.

Supplementary programs to overcome specific barriers to improved health in rural areas—such as transportation services, outreach services, environmental health services, home health services, patient education services and nutritional services—should be developed.

Creation of a health resources development board with sufficient funds targeted on personnel who desire to locate in rural communities and on the development of innovative approaches to health care delivery in rural areas.

Recognition of community sponsored health centers meeting specified stand-

ards as providers of health services eligible for direct reimbursement.

Reimbursement for services of non-physician health professionals at rural health centers whether a physician is physically present or not when the service is rendered.

Establishment of fee schedules for physicians that reward rather than

penalize physicians for practicing in underserved areas.

Comprehensive health centers currently funded by the Department of Health, Education and Welfare should be maintained rather than cut back as proposed by the Ford Administration. The Medicare and Medicaid programs should be amended to permit comprehensive health centers to receive capitation payments from these programs based on average expenditure levels for all persons covered by Medicare and Medicaid in the state. Attempts should be made to upgrade the environmental health, home health, patent education, dental, mental health and nutrition activities of existing centers. Administrators should have opportunities to visit other centers which make effective use of these support services. Better technical assistance from the federal and regional offices of the U.S. Department of Health, Education and Welfare should be provided to existing centers. Evaluation studies regarding the payoff of different types of support services for different populations should be conducted. Consideration should be given to establishing additional comprehensive health centers in rural areas with severe health problems.

Presbyterian Medical Services, Santa Fe, N. Mex., March 23, 1977.

Re Written Testimony on S. 708.

Hon. DICK CLARK,

Chairman, Senate Rural Development Committee,

404 Russell Bldg., Washington, D.C.

DEAR SENATOR CLARK: Thank you for your and Senator Leahy's letter of March 7, 1977 inviting us to comment on the above referenced legislation.

Some of our comments have already been presented to you through the New Mexico Hospital Association. Additionally, Mr. Fred Mondragon, President of the Association, will be presenting oral testimony on March 29. Mr. Mondragon and I have discussed his testimony and I am sure you will find it extremely valuable.

We support the legislation as printed in the Senate Congressional Record of

February 10, 1977.

In northern New Mexico, we provide health services in 29 separate locations; 13 of the locations provide a full range of health services and at 16 sites we provide certain health support services in such fields as pharmacy, data processing, communications, management consulting, etc. At the full service sites we employ about one-third of New Mexico's licensed nurse practitioners and physician extenders. Our service area encompasses approximately 25,000 square miles.

The 1970 U.S. Census indicates that approximately seven percent of the total New Mexico population is over the age of 65. In our rural service area, we find this population subgroup to be about 11%. Additionally, we find that people in this group seek care more often than others; approximately 15% of our medical encounters are with Medicare-eligible people. Therefore, we estimate that at least 15% of the services provided by our nurse practitioners and physician assistants are not reimbursed. The dollar volume of such services is

significant, especially for a non-profit corporation operating in rural areas,

simply struggling to break even.

The reimbursement mechanisms under Medicare for physician extenders should be maintained as closely as possible to the mechanisms in place for reimbursement to physicians. Standardization of the claims process will enhance the efficiency of our administrative personnel in the actions and record-keeping necessary for the appropriate submission of claims. Fees approved for physician extender services should be not less than 66.6% of the usual and customary fees charged by physicians for such services.

In our opinion, the legislation identifies the necessary elements which a clinic should be required to fulfill in order to qualify for reimbursement. We strongly recommend that regulations developed by the Secretary pursuant to the legislation, if enacted, be accomplished by a task force of people from around the country who are directly involved in the provision of health services in rural areas along with appropriate rural consumers of health care. We would be

pleased to participate.

In terms of certification, providers whose services would be reimbursed should be, first and foremost, licensed or certified by the appropriate State Board of Medical Examiners or Board of Nursing Examiners. Certification of fulfillment of administrative requirements pursuant to the regulations should be done by the existing Federal Program Certification personnel in each state, in a manner which would be, at the very least, no more complex than the existing Federal Program Certification process.

Again, thank you for the opportunity of presenting the foregoing written testimony. If you have questions or need additional information, please call on

me.

Sincerely yours,

Bob Clements, Vice President and Chief Executive Officer.

CLINGMAN MEDICAL CENTER, Ronda, N.C., March 25, 1977.

Re Testimony for Senate Bill 708. Senator Dick Clark, Attention David Harf, 404 Russell Bldg., Washington, D.C.

Sir: I am a family nurse practitioner and director of a rural health center. Approximately 10% of our patients are Medicare recipients. These patients have no other alternative for their primary care except to come to our rural health center or the local emergency rooms. Due to the severe physician shortage in our area, the physicians are so overworked that they cannot accept new patients. Those who do see a physician have to wait as long as three to four hours to be seen. Their wait is usually only a few minutes at our center. The shortage is so severe that many of the physicians in this area see 60-80 patients a day. They have seen as many as 100 or more patients per day. With a shortage like this there is very little time for the patient to express their concern or to receive a truly complete exam.

I feel the passage of this bill is imperative to help make health care more accessible to the Medicare patients. These persons are forced to choose between

no health care or health care which is not recognized by Medicare.

The bill as it now stands is adequate in my opinion. I would, however, like to comment on the certification process. I feel this aspect of the bill should be very flexible as standards of certification are changing rapidly at this present time. The ANA Exam has only been given one time November 20, 1976. I do not feel the impact of an exam of this nature has yet been realized. I did take the exam and am certified but does this fact alone make me a competent practitioner? I feel successful completion of a recognized program of training as a physician extender is much more important than an exam.

I feel this legislation is of utmost importance and hope this testimony will

help in some way to speed its passage.

Sincerely yours,

PANHANDLE HEALTH DISTRICT I. Coeur d'Alene, Idaho, March 25, 1977.

Mr. DAVID HARF. Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: Thank you for the opportunity to express my opinion con-

cerning the Rural Health Clinic Bill.

I feel Bill S. 708 would be of great value to rural areas such as in Northern Idaho. For example, at present the Panhandle Health District is operating a clinic facility in the community of Spirit Lake, Idaho, which has a populus of 850 people whose nearest source of medical care is 26 miles. This facility is manned by a Registered Nurse Practitioner sponsored by a physician in Coeur d'Alene, Idaho. The community members have come in increased numbers for all types of medical care. However, due to the cost of maintaining the facility it is a probability the Health District may have to close this center. There are numerous other similar areas in Northern Idaho.

If the Rural Health Clinic Bill (S. 708) is passed it would possibly mean continued care for people such as these with financial assistance for equipment, supplies, and possibly treatment regimen supplies.

As to personnel, certification of Nurse Practitioners could be either through the state in which the nurse practices or through the National Association for Nurses Certification. I believe many physicians would assist as consulting agents if somewhat reimbursed, possibly on a flat rate percent for each consultation.

I feel this is a most worthy bill and would provide medical services where they are badly needed and have long been neglected by other legislation.

Sincerely yours,

ELLA GORDON, R.N./R.N.P. Public Health Nurse.

RURAL GROUP PRACTICE, Farmington, Me., March 22, 1977.

Senator DICK CLARK,

Chairman, Senate Rural Development Subcommittee, In care of David Harf, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR SENATOR CLARK: Your senate bill S. 708 is certainly a necessary change in the current Medicare regulations. In order for our group practice to continue to provide health care to the communities in which we have satellites, thirty and fifty miles distant, it is essential that the nurse practitioners and/or physician assistants who staff these offices be reimbursed for their services when their services are provided in a supervised manner by our precepting physicians. Our state laws do not require the actual presence of a physician, and this is indeed impossible if one is to provide care in these remote areas. It is financially not feasible to maintain these offices if physician assistant reimbursement is not obtained. In many cases, despite their knowing that Medicare will not help them cover the cost of it, many Medicare covered patients ask our physicians assistants nevertheless to make housecalls, etc., and then pay for these out of their own pockets.

As far as certification process used to supervise providers, I think our State Board of Registration of Medicine has drawn up model rules and regulations to control the use of physician assistants, and I enclose a copy of them for your

perusal.

Sincerely yours,

DANIEL K. ONION, M.D., M.P.H., Associate Medical Director.

PRIMARY HEALTH CARE SYSTEMS, INC., Portage, Pa., March 23, 1977.

DAVID HARF. Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR SENATOR CLARK: We are indeed honored that you have requested input from our organization concerning Medicare reimbursement of P.A.'s and N.P.'s. To briefly outline our background, we have been involved in delivering primary ambulatory care for 10 years in rural southwestern Pennsylvania and presently operate 5 rural health facilities. We have been involved in the P.A. concept for 6 years and not only use them in the delivery of health care but also are involved as training sites for the Yale, Johns Hopkins, and Hershey Medex programs. Our experiences have been very positive from both delivery and patient acceptance of these health professionals.

To specifically address your request:

(1) Reimbursement of P.A.'s would allow them to be more fully utilized in relation to their training, permit expanded services, ease of access to health care, and limited emergency services. Preventative health care, patient and community education, and simply a focal point to relate to health care are only a few of the positive spinoffs in this area.

We are aware of many physicians in rural areas that would employ P.A.'s but are wary of the no-reimbursement clause and the "heavy heavy what hangs over" label of medicare fraud, a definite deterrent to the utilization of these

health professionals.

Recruitment of physicians to rural areas could be enhanced by having P.A.'s share the workload of the rural physician while being cost effective. It is our fear that if Medicare reimbursement is not enacted, the present trend of P.A.'s going to rural areas will be reversed and they will migrate to the areas of greater physician population, thereby negating the whole P.A. concept.

(2) The method of reimbursement could become a complex issue. We believe the simplest solution is: If a P.A. provides services similar to those a physician would provide, the fee for this service should be the same. If a lesser service is provided than a percentage of the fee or a separate fee schedule should be developed for these services. We also believe this fee should be paid to the phy-

sician employing the assistant rather than directly to the P.A.

This above concept would eliminate the complexities of extra bookkeeping, accounting, and the danger of using the reasonable cost mechanism. This opens the door to projected budgets, direct and indirect cost ratios, budget justifications, a maze of rules and regulations, and the possibility of the P.A. being paid more than the physician if the reasonable cost is justified. The listed complexities would increase the cost of administering this program thus decreasing the amount of monies available for direct patient care.

Perhaps the quality assessment mechanism currently being developed by PSRO's could be utilized in maintaining quality of care and act as the basis

of "same service for the same fee."

(3) The requirements for clinic supervision, mangement, and referrals as outlined in S. 708 are in agreement with our thinking in these areas. The one exception is in the area of preparing written medical orders for care and treatment of patients. This appears to refer to written protocols for the P.A.'s.

It has been our experience that writing protocols for P.A.'s is a difficult, costly, time consuming, and almost impossible task for the average practicing rural physician. Among the best protocols we have seen are those developed by Dr. A. Kamoroff at Beth Israel Hospital in Boston. This has been a full-time effort on his part over the past 3 to 4 years dealing with 10-12 of the most common diseases and they are not designed exclusively for use by the P.A. We feel it is more reasonable and proper to permit the supervising physician and his P.A. to establish their patterns of care and disease management that is appropriate for their situation. This permits the utilization of the P.A. in the manner outlined in the original P.A. concept and provides the flexibility needed in rural settings while maintaining the close relationship of physician and P.A.

(4) We concur with the certification process as outlined in S. 708. We do not

concur with the process as outlined in HR 2504/HR 3113.

We feel that the passage of this legislation will be a major step forward in the struggle to provide health care to rural areas. We would like to commend you and your co-sponsors for your efforts in this area and wish to offer the benefit of our experience in this area to you and your committee if it would be helpful.

Sincerely,

JOHN ROSS, P.A.-C President, J. D. MICHAELS, Secretary-Treasurer, R. MRKICH, M.D. EAST TENNESSEE HEALTH IMPROVEMENT COUNCIL INC., Knoxville, Tenn., March 23, 1977.

Mr. David Harf, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

Dear Senators: The East Tennessee Health Improvement Council, Inc., in its role as the regional health planning agency of Health Service Area-II in Tennessee is deeply concerned about the urban bias of the health care reimbursement system. Many of the primary care clinics in Appalachia could not be self-sufficient even if they had a full-time medical doctor. Physician extenders could be an answer to the needs of these people. They would cost less, be more retainable for the community, and could provide primary care that is desperately needed by the citizens of these communities who are isolated from each other both by geography and by mountain mores which generate fierce community pride.

community pride.

ETHIC supports the concept of free-standing community primary care clinics. However, we do recognize that changes in the reimbursement mechanism need to be brought about in order for these clinics to become financially

viable.

We feel it is unjust for rural elderly persons to continue paying part B Medicare premiums and be denied available treatment at clinics which may be the only reasonably accessible primary care site in their area. At the present time, it is our understanding that the federal government is working against itself by financing and encouraging physician-extender clinics while withholding Medicare reimbursement for services provided by these same physician-extenders. Certainly the situation should be resolved as quickly and efficiently as possible to avoid using the taxpayers money to work at cross-purposes.

Citizens, doctors, and clinic administrators from our area are expected to submit written testimony concerning this matter also. We hope that their comments are given serious consideration as they are the people who deal with

these problems on a day-to-day basis.

Thank you for providing us the opportunity to make these comments.

Sincerely,

Jeff Johnson, Chief, Medical Facilities Planning and Project Review.

> CHEMUNG COUNTY HEALTH COALITION, Elmira, N.Y., March 23, 1977.

Mr. David Harf, Office of Senator Dick Clark, 404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: Enclosed please find a copy of a position paper from the Chemung County Health Coalition on the need for revision of the Social Security Act re: Medicare Reimbursement of Physician Extenders.

If you have any questions you can call me at 607-734-6174. Thank you for your attention of this most important matter. Sincerely yours,

HERBA JEAN CLARK, Staff Coordinator.

Enclosure.

Chemung County, New York, situated on the Pennsylvania border, has a population of about 100,000 with approximately 30% of this population in the rural areas. 16% or 16,0000 persons are over the age of 60. Chemung County is not large enough to qualify for a National Service Corps physician, but three towns within the County have been designated as Medically Underserved Areas by the Finger Lakes Health Systems Agency.

Transportation is limited to the urban areas of Elmira, Horseheads and Southport, mass transportation does not exist outside these areas giving residents, having no transportation, little opportunity to reach health services in

the urban areas.

In 1974 the Chemung County Economic Opportunity Program, Inc., received funding from the Appalachian Regional Commission for three rural health

centers located in areas over twenty miles from two urban hospitals, and medical facilities all located in the city of Elmira. These centers are staffed with Physician Associates and receptionists with one Community Health Worker and supportive Physician coverage and back-up. This program meets the primary health care needs, which includes complete physical exams with EKG, immunizations, some laboratory, treatment for chronic and acute illness and

limited emergency treatment with referral for specialized treatment.

Since its inception, the Comprehensive Rural Health Maintenance Program has encountered several obstacles in reimbursement, one of which has caused much inconvenience to the elderly patients that are being served. The major problem has been reimbursement for medicare patients. The program's supporting physicians are scheduled at the centers two half-days a week which means, to be reimbursed, the patient can only be seen when that physician is on-site, which at times, is difficult because the physician has to review all patient records on a weekly basis thus limiting time that patients can be seen. Scheduling patients with the physician is necessary when there is a need for a second opinion, or sometimes as need indicates on a routine basis of every third patient visit. This scheduling problem causes undue stress on the elderly patient and causes a break-down of the total efficiency of the program. Many elderly are also discouraged from using this service because payment is requested at the time of their visit and they then have to request their own reimbursement from Medicare after they have already paid their \$7.60 premium per month for Medicare Part B coverage. Unfortunately many elderly are not capable of even completing the forms!

Another program in Chemung County that would benefit highly by medicare reimbursement revision is the Geratric Primary Care Program sponsored by St. Joseph's Hospital, which does not have a fee for service, except upon referrals to a physician in the EMA group which is only at the patient's option. This program is staffed with Nurse Practitioners and is located in the elderly housing projects in the City of Elmira with home visits, screening programs, and other supportive services conducted throughout the County. The Geriatric Primary Care Program provides preventive care and follow-up, including home visits to assess the needs of the patient and give the Physician Associate or physician a comprehensive profile of the total family so that whatever indicated supportive services are needed can be provided.

This not only holds true with the above mentioned ARC funded programs but also is true of Physician Associates and Nurse Practitioners working with private physicians because they provide services such as home visits which

allows the physician to provide more acute care.

Medicare Part B, Supplemental Medical Insurance, was written before physician extenders were commonplace. Even during hearings on the major Social Security Act Amendments of 1972 (PL 92-603), the extenders were few in number, and their medical future was uncertain.

Part B allows reimbursement only for physician services and services fur-

nished "as incident to a physician's professional service and of kinds which are furnished in a physician's office or clinic and are commonly either rendered without charge or included in the physician's bill." (Regs. 405.231). In practice, this has come to mean that Medicare services for which a physician's signature can be obtained on the day of rendering are reimbursable.

This is particularly ironic since the Appalachian Regional Commission and HEW health programs are increasingly encouraging the use of Physicians Associates and Nurse Practitioners (Physician Extenders) through new and innovative approaches to health care delivery, however, because of the present system, Physician Extenders can not be reimbursed by Medicare for payment

of their services.

It should also be noted that because extenders' services are not presently reimbursable by Medicare, their willingness to locate in underserved areas is being arrested. Six of the Nation's 50 physicians assistant training programs

were expected to end in 1976 because of trainee job uncertainty.

The Chemung County Health Coalition strongly encourages the passage of the Senate Bill S 708 to amend Title XVIII of the Social Security Act to provide reimbursement for Physician Extenders in rural health centers and also supports an amendment that would provide Medicare reimbursement to all Physician Extenders regardless of whether rural or urban since there would be much less money spent on the administrative costs involved in defining rural areas, prohibiting fraud and defending charges of discrimination.

GILLIAM COUNTY MEDICAL CENTER, Condon, Oreg., March 22, 1977.

Senator Dick Clark, Senate Rural Development Subcommittee, Hearing Regarding Rural Health Clinic Bill, Washington, D.C.

Sir: I appreciate the opportunity of giving written testimony concerning Senate Bill #708 regarding the reimbursement of physician extenders for their services rendered to Medicare patients. The attachment, listed as exhibits 1, 2, 3 and 4 contain paragraphs which may help explain some of the concerns I have regarding the delivery of health care in rural America where there are a lot of difficulties created by the nonreimbursement of primary care professionals who are not listed at the present time, on the Medicare Bill.

There are four points I wish to make in which the Rural Health Clinic Bill would be beneficial to rural communities such as mine, in making sure there

are professionals available for primary health care.

1. Paragraph four of exhibit 3 indicates that between July 1, and December 31, 1975, \$5,096.33 were denied my patients and my clinic by Medicare. I think it would be redundant to say a small clinic of my size (paragraph 2, exhibit 2) wherein we are dealing with a very tight efficiency ratio between money received and money utilized in maintaining the clinic, that \$5,000.00 during one half year is too large an amount to keep this clinic functioning. At the present time, since so many people were denied (during the 1975-76 years) for their Medicare expenses in this clinic, many have decided to go elsewhere or have just stayed from having health care. The result has been much more devastating disease occurring in the community or a tremendous waste of energy, having the patients go 70 miles for health care, where Medicare would pay for the services. This results in a trip that could have been avoided had reimbursement been possible here.

The result of all this has been a very marginal rural health clinic which we have at Gilliam County Medical Center since going private on Aug. 1, 1976. It has never produced the salary I was previously making while with National Health Service Corps, but wished to get on our own feet to avoid further involvement of Government subsidy in this area. There is still some question of our viability without county monies to help us keep out of financial difficulties. Never being reimbursed for services is not only totally absurd, but very difficult to understand. All of the services are on a very tight cost ratio which means that the clinic is not only losing on reimbursement, it is losing from the standpoint of providing the care, of paying vendors for materials, (laboratory tests and so on) to be done for proper care for these people, and then never

receiving a dime in return.

2. With regard to reimbursement of services, it seems that there should be no difficulty in the reimbursement being made on the basis of the service. Certainly fixed costs which apply to other clinics around the country are just as applicable to the satellite rural health clinics as they are to any other. It costs money to pay utilities, it costs money for equipment, it costs, in many cases, more for a rural health clinic to obtain laboratory tests and further sorts of services than it does the clinic in a city like Portland, or other cities of any size. For anyone to say they are less, they should come and take a look. It is my opinion, based on actual facts that I am aware of, that small, rural health clinics are already charging fees much below those fees charged for the same services other places in the state, especially in the more urban areas. Therefore, cost efficiencies are gained by rural health clinics already, so why not reimbursement on the basis of what the rural health clinics are already charging.

3. With reference to the policy or factors under which the clinics would be reimbursed, I think one would find the states are taking care of certification and regulation of these physician extenders as they are called. The States Board of Nursing are already controlling the certification and conditions under which practice will be maintained, with reference to Nurse Practitioners. Medical Boards, and Boards of Medical Examiners are presently controlling conditions and certification of Physicians Assistants. It would seem very inappropriate for further regulation to be necessary under this bill, as it is obvious no other health care professional is regulated nationally, but rather regulated by in-

dividual states. Certainly, this would decrease the duplication of effort. One would also find that the Physician Assistants as well as Nurse Practitioners are engaged in every effort possible to see that professional and safe care is given to their clients. Most are complying with or trying to upgrade themselves for recognition with National as well as State certification. This is the case of every physician extender I am aware of, and I know several. National Certification through ANA or through the national American Academy of Physician Assistants has already started. In my case, I have taken both board exams and am certified under both as I was trained under both, as one can see from exhibit 1.

4. With reference to referral arrangements and scope of practice, etc., which seems to be a concern of the committee. This is also covered under most of the laws, rules and regulations adopted by Boards of Nursing and Medicine which requires a scope of practice, referral base, as well as identifying those who are on their professional performance review committee. This involves either Nurse Practitioners, other Physicians Assistants and includes physicians. In exhibit 4, you will find my scope of practice with the consultants I have available within the state of Oregon. My professional performance review committee is composed of two M.D.s, and two other Family Nurse Practitioners.

Thank you again for this opportunity.

Sincerely,

G. JAY BUTLER, FNP.

Enclosures.

[Exhibit 1]

Provider of Primary Health Care: Gordon Jay Butler, R.N., (M-), F.N.P.,

Age 43, male.

Background: Army Medical Corp. Korean War, Pre-med student prior to and after Army service, R.N. 1962 Weber State College, B.S. 1963 University of Utah, Emergency Room and Med. Surg. Nurse Hospital 2 years, Assistant to Pediatrician for 3 years, Pharmaceutical Professional Representative 7 years, Medex Northwest (U. of Washington) graduate 1973, Certified F.N.P. in Idaho 3 years.

Presently 11/2 years of employment at the Gilliam Medical Center.

My work experience, in addition to formal education represents: 7½ years of close supervision and instruction by M.D.'s, 2 years as hospital nurse in ER or Med. Surg., 7 years of pharmacology, and 2 years of concentrated training and experience in the Army Medical Corps.

Insurance Companies which are presently paying claims of my clients under group and/or independent policies: First Farwest, P.H.A., Western Farm Bureau, Beneficial National Life, and Blue Cross.

Insurance Companies for whom I am an examiner: Western Farm Bureau, MONY, Beneficial National Life, P.H.A., and Equitable Life.

[Exhibit 2]

President JIMMY CARTER, The White House, Washington, D.C.

DEAR PRESIDENT CARTER: The following letter and its attachments are for your information in getting acquainted with some of the problems in rural

health care in these United States.

Our town of Condon, Oregon has a population of approximately 900 with an outlying area of surrounding farms and ranches, perhaps having a total population of 1500-1800 people. Health care for this area is now provided by me, a Family Nurse Practitioner, trained at the University of Washington under funds from the Department of HEW which was provided by previous administrations. I was placed here and helped for approximately one year (until a clinic could be established that would be able to stand on its own feet), by the National Health Service Corps, which is a division of the Department of

You can tell, so far, the Federal Government has had a great deal to do in helping this community obtain some health care which was previously unavailable. Private physicians left, one after another with only a short stay. This is understandable, as the emergency calls come night and day, seven days a week, 365 days a year and no one to spell the provider off during this period of time.

With the aid of the Rural Health Initiative Program out of Region X in Seattle, Wa., we have what is called the Tricounty Health Commission which has set up the practice of two Nurse Practitioners with a third one to give us relief from time to time. The man in Fossil, Ed Struwe, is also a Family Nurse Practitioner and his clientele comes from a population of approximately 1800. Together, we are able to provide this area with good health care services which are unavailable for a distance of some 70 miles over rather difficult to travel roads . . . even in the summertime.

We have two concerns which are giving us difficulty presently and in the future in relation to the Federal Government. Number 1. We are not recognized as providers of health care by Medicare or Medicaid. 2. As of now, there has been no determination or provision on any bills (that we are aware of) for a National Health Insurance Program which recognizes the Family Nurse Practitioner as primary providers of health care in small communities which are

far removed from other health or medical facilities.

We now have in operation in this area, the combined effort of a team of primary providers of health care. Two Nurse Practitioners who are working full time, one as a backup and two physicians who are aiding in providing consultation and other services as needed. If looked at closely, it is working rather ideally for rural portions of America like this part of the Central-Eastern portion of Oregon. I wish to offer an invitation for you, your representatives or anyone in the Federal Government who would be interested in looking into our particular setup here to please come and take a look. We are anxious to have people who are in the policy making part of the Federal Government see what we are doing. To see that there is an inequitable problem that faces us with regards to reimbursement for our services. It is not our intent to become wealthy. Our intent is to be able to make a living and to keep our clinics functioning. Nearly 200 of my patients are recipients of Medicare, and none of them are able to pay for their services. This amounts to several hundreds of dollars in one year, and one can readly see that the viability of this clinic is in jeopardy. Lack of provision by Congress and the HEW Department is certainly going to defeat the purpose of another segment of the HEW, that being the National Health Service Corps.

Your kindness in spending only a moment or two of your busy schedule in

G. JAY BUTLER, MX, FNP.

reflecting on this situation is certainly appreciated.

With kind regards for a successful administration.
Sincerely,

[Exhibit 3]

Senator Mark Hatfield, 107 Pioneer Courthouse, Portland, Oreg.

Dear Senator Hatfield: Since my original letter to you concerning Senate bill #104, and my concern about the inability or the lack of authority given Medicare people to pay Nurse Practitioners, I have been able to gather some information which may be handy.

Mr. Ernie Fatland has been so kind as to bear my leg work and do some of the talking with officials around the state, especially yourself and Bob Packwood concerning the plight which seems to be facing my clinic and others in the state in rural areas where Nurse Practitioners are filling the gap left by

physicians who have long since left the scene.

As alternative health care providers, it is important that we be considered worthy of Medicare reimbursement inasmuch as we are presently giving the service and are undergoing some real cost problems, i.e. not being reimbursed for the services we do give. In my case, however I have a Nursing Home in addition to my outpatient clinic which will increase, perhaps, the amount of Medicare monies that are due the clinic over and above those found in a family practice elsewhere in the state.

The total amount of monies due this clinic and/or our patients who qualify as Medicare recipients from July 1 until December 31, 1975 was \$5096.33. About 177 patients are involved in this amount.

I hope that from this, you will be able to find some information which will be helpful in your deliberations in the Senate in determining what must be done to alleviate this rather unjust economic barrier which prevents primary health providers of my background and others like me, who are having difficulty with this economic burden placed on our clinics. Inasmuch as we are rather marginal clinics anyway, with difficulty making the revenue possible for an M.D. to feel that he can make it here, Nurse Practitioners can make adjustments and do not, apparently, require the larger salary most M.D.'s require. However, we have some real costs which must be met and have families and other expenses that are necessary for our maintaining an income which is compatible with our needs. I am sure you can see with nearly \$1000.00 per month to be written off as a total loss to this clinic would bring us down in a hurry.

We sincerely appreciate your concern about this situation and hope we take the necessary steps to see that you will help us in any way you can to alleviate this pinch we are going through now. Being pioneers in the area of health care, I understand that there are a lot of things which we are accomplishing now which were not really planned for by the original writing of the Medicare

Law.

Our sincere thanks,

G. JAY BUTLER, MX. FNP.

[Exhibit 4]

Below is the Scope of Practice of this provider and may be revised as may be-

come necessary in the view of the provider.

The scope of practice is divided into three categories. The purpose of which is to show the items provided which are essential to the community. The greatest list is that of community convenience. This represents items which are not an emergency to provide but are convenient due to our remoteness from other health care providers. The third list represents areas of health care which have been and will continue to be areas of no involvement of this provider. As soon as assessment determines that a patient requires any of the items under this category, he/she will be referred to a physician of the patient's choice or one of the listed consultants.

Assessment means taking and recording medical history and physical examina-

tion plus appropriate non-invasive tests.

The following are diagnosis for which assessment and lab tests may be necessary to confirm. It is therefore understood that scope of practice involves obtaining necessary evidence for diagnosis as well as treatment of same. It is also understood that under certain conditions, diagnosis will be deferred when stabilization and transfer of the patient is deemed most important.*

COMMUNITY NEEDS

Otitis media Foreign body, eye Foreign body, ear Foreign body not involving body Cellulitis involving soft tissue Acute myocardial infarction* Pulmonary edema Acute emphysema Acute asthma Poisonings Insulin shock* Diabetic coma Acute abdomen (screening)* Trauma (screening)* Insect stings

Animal bites Burns Drownings or other severe airway emergencies Environmental shock (electric, etc.)

Advising of course of action after screening assessment

Lacerations not involving tendon, nerve, artery or major cavity

Providing or arranging for provision of 24 hour emergency health care each day

Train and maintain competence of local EMTs

Provide sports health care for community schools.

^{*}This list is continuing to expand and is, therefore, incomplete.

COMMUNITY CONVENIENCE

Influenza

Bronchitis Pharyngitis Otitis externa Middle ear inflammation External hemorrhoids assessment for General physical screening Urinary tract infections Vaginitis Prostatitis Hypertension Follow up congestive heart failure Chronic obstructive lung disease Follow up transient ischemic accident with consult PAP smear and assessment which includes breast and rectal exam Follow up gout Follow up osteoarthritis Follow up diabetes mellitus Obesity Follow up rheumatoid arthritis Mild neurosis and mild psychosis with

Hay fever Follow up ulcer (peptic-duodenal) Hiatal hernia Excision of minor skin lesions with pathological report Simple undisplaced fracuture Minor sprains and strains Dislocations with consultation and xray verification Well child clinic with immunizations Community immunizations Eczema, hives (persisting referred) Contact dermatitis Tension and migraine headaches (mild. Referred if unresponsive to simple treatment) Counseling on preventative health

Teaching proper health maintenance Provide public health services to Con-

Provide assessment for school physical

don area citizens

examination

Arteriosclerosis with consult

AREAS OF NO INVOLVEMENT

Situations involving any controlled substance

Pre and post natal care and obstetrics

mental health consult

Follow up on gynecology problems beyond acute infections of vulva and/or vagina Displaced fracture or any fracture requiring reduction or involving articulating surface or growth plate.

All surgery except excision of minor skin lesions and repairs of lacerations as

indicated in "Community Needs"

CONSULTATION

(M.D.'S UNLESS OTHERWISE INDICATED)

Orthopedics: Schwartz, Bruce

Staver, Robert

Cardiology: Semler, Herbert

Neurology:

Snodgrass, Glenn Lahiri, Richard Wilson, Jacob Neurosurgery:

Miller, Ray Raaf, John

Misko, John

Urology:

Young, Don Albrich, Jerald Ellis, Wm. J. Sandoz, Ivan Paull, David P.

OB-Gyn:

Langley, Ivan Tarnasky, John

Surgery:

Rice, Robert D'Souza, Aloysius Collis, Reyburn Adams, Thomas

Colon, Rectal Surgery: Sullivan,

Pediatrics: Guenther, Donald Podiatrist: Aizawa, Hide R.

E.N.T.:

Hansen, Robert Hodgson, Richard Mettler, Don

Radiology:

Gehling, Vic Gay, Allen

General:

Carpenter, Richard Gifford, Joseph Rozendal, Robert Wilcox, Dean

Ophthalmology:

Till, Bruce McDaniel, David Other Health Professionals:

Ed Struwe, FNP Kenna Shean, Psych. R.N.

Allen Hammer, R Pn.

Internists:

Weil. Steve Selling, Phillip Stevenson, Edward

Dermatology: Woodward, Richard

Eugene

STATEMENT OF CARYL E. CARPENTER, MOUNTAIN PEOPLE'S HEALTH COUNCIL, INC., HUNTSVILLE, TENN.

I am administrator of Mountain People's Health Council, Inc., a coalition of three primary care centers located in the Appalachian region of East Tennessee. Each center is located in a county which has been designated as a medically underserved area and in communities that are isolated from the limited medical resources that are available. Our centers were organized by community groups who were responding to a serious need in this area — the need for primary care services. These groups formed community health councils which raised money through quilt sales, pie suppers, baseball games and gospel singins. They formed the coalition to seek Federal funding to help start the centers.

By 1979 the centers must be financially self-supporting. This means we must charge patients or third party carriers for services while at the same time trying to provide services at the lowest possible cost. Developing a self-supporting financing scheme is a difficult task for a rural clinic because most reimbursement plans are categorically defined. A rural clinic may serve only a few people in each category and often the paperwork associated with these programs hardly seems worth the small return. In addition, not all of our services are covered. For example, a woman may make a family planning visit and have it covered by Title XX but when she needs treatment for a cold she is not eligible for Title XX coverage. This situation is as difficult to explain to

the patient as it is to administer in each center.

Medicare reimbursement policies are another example of the problems in financing rural health services. Currently, Medicare will not reimburse the centers for services provided by non-physician providers such as nurse practitioners. Because a physician is only on-site once or twice a week, we often provide services to Medicare beneficiaries without charge. It is very difficult to coordinate the health care needs of people over 65 with a physician's visit schedule. Senate Bill 708 would represent an important contribution to our efforts to serve rural people and become self-sufficient. We feel that nurse practitioner services are a viable solution to the problem of manpower shortages in rural areas and represent an appropriate style of care for underserved populations because they include patient education and counseling services in addition to basic medical services. In addition, this bill could rectify the current contradiction in Federal policies which help support nurse practitioner training programs, place NP's in rural areas but do not reimburse for their services.

I would also like to add some specific suggestions about administration of

Medicare reimbursement for non-physician providers:

1. It is imperative that we have the same reimbursement arrangement for both nurse practitioner and physician services. It will be both confusing and costly to bill to separate carriers depending on the type of provider.

2. It is also important to base the reimbursement on reasonable cost. This is an option currently available to Federally-funded clinics which have full-time physician coverage. It would provide an incentive for rural clinics which does not always exist in the categorical programs as I have described them.

- 3. Billing for Medicare beneficiaries would also be considerably simplified by eliminating the deductible. At our centers, we often refer to specialists. It becomes very time consuming to keep track of the status of a patient's case, each of whom is billing Medicare. The alternative is to have the patient pay all the bills directly and bill Medicare himself. This is almost impossible for many of our patients who are not literate. Collection of a straight 20% coinsurance on each visit would be much simpler for both the clinic and the patient.
- 4. With regard to specific clinic policies, I think the following represent reasonable expectations of any primary care center:

(1) That a medical record be maintained on all patients.

(2) That written protocols be jointly developed by the non-physician provider and supervising physician and be updated annually.

(3) That all nurse practitioners become certified within three years after

the bill is passed.

- (4) That the supervising physician visit the clinic at least once a week or review records with the NPP once a week.
- (5) That the clinic have an internal system for quality assurance such as flow sheets, chart audits or problems lists.

(6) That the clinic have established referral arrangements for secondary care including hospitalization and provisions for record transfers.

(7) That clinics have an appropriate accounting system such as the one used by most National Health Service Corps sites and have an annual audit.

The nurse practitioner concept has been well-received in our communities and the centers have strong community support. We welcome any change in reimbursement policies which will improve our ability to serve rural people.

> LATAH CONVALESCENT CENTER, Moscow, Idaho, March 18, 1977.

Hon. Dick Clark, U.S. Senate, 404 Russell Bldg., Washington, D.C.

My Dear Senator Clark: This letter is written in support of S. 708, the bill currently under consideration that would permit Medicare reimbursement to

rural health clinics for primary health services.

Latah Convalescent Center is a county-owned, non-profit, extended care/skilled nursing facility that has been serving the residents of Latah County and the surrounding area for 20 years. In keeping with our goal of continually upgrading patient care, we have given our Director of Nursing Services a leave of absence for 4½ months to attend the University of Colorado School of Nursing. Upon the completion of this training she will be qualified as a Geriatric Nurse Practitioner.

Obviously the objective of this added training is to improve patient care, while relieving the local physicians of the more routine tasks involved in providing that care. The program itself poses no immediate financial problems for us with the Title XVIII program. We are certified for both Medicare and Medicaid, and the cost of care given within our facility is reimbursable. However, we can forsee in the future an opportunity to provide an even wider service to residents of this rural area by means of out-patient assistance —

provided that adequate reimbursement is available.

People served by a Geriatric Nurse Practitioner are, obviously, those most likely to have Medicare and/or Medicaid assistance. The health problems of these senior citizens are myriad. Many of their complaints are serious, but an even greater number may be of a type that do not require the immediate attention of an M.D. It would certainly be more effective and far less expensive to serve these people with a physician extender and allow our overworked physicians to care for those who really need their attention.

S. 708 is most certainly a step in the right direction. I earnestly solicit the

support of your committee toward the passage of this needed legislation.

Sincerely,

J. W. WATTS, Administrator.

VERMONT STATE HOSPITAL, Waterbury, Vt., March 18, 1977.

Hon. Patrick Leahy, Senator, U.S. Senate, Senate Bldg., Washington, D.C.

Dear Senator Leahy: I am, of course, in complete agreement with every detail of S. 708. However, I greatly fear that its value will be seriously limited in states like Vermont where the eligibility level for Medicaid is so low that the working poor are excluded. If our experience with this problem in community mental health centers in rural areas is any indication, more than half of those who cannot pay for their care are not eligible for Medicaid. Both rural mental health clinics and primary health services are suffering badly from this serious deficiency in Medicaid regulations. Federal support is being withdrawn and funding becomes more precarious each year. If the Bill is intended to provide more stable funding for essential health services in rural areas, some attention should be given to this very serious deficiency. Thank you for your interest.

Sincerely,

Tuscarawas County General Health District, Dover, Ohio, March 18, 1977.

DAVID HARF,

Office of Senator Dick Clark,

404 Russell Bldg., Washington, D.C.

DEAR MR. HARF: I would like to make the following comments regarding health services provided by Nurse Practitioners and Physician's Assistants, which will be discussed in Senate Bill 708.

1. How would legislation of this sort assist small communities in your area

and throughout the country?

This county is medically underserved with a critical shortage of family practice physicians. The use of Nurse Practitioners and Physician's Assistants would be very beneficial to provide primary care and preventive health care under the standing orders of a physician. This would provide the population with services that many physicians and hospitals do not provide because they refuse to care for patients with medical cards. It would insure at least complete physical examinations, treatment of the usual uncomplicated illnesses, and emergency treatment. Patient records would be centrally located and plan of treatment would be consistent and beneficial. Progress would be noted easily.

2. In what manner should reimbursement be made for the services provided

by Nurse Practitioners and Physician's Assistants?

Reimbursement should be made through the agency providing the service.

3. What requirements should a clinic fulfill, in terms of such factors as physician participation, arrangements for referral, and management policies, in

order to qualify for reimbursement?

The clinic itself should meet certification requirements (similar to those of an ambulatory Health Care Center). The practitioners should be from accredited schools and should be certified. The testing for certification should be commensurate with the undertakings of the responsibilities. (Accredited PNA and NP schools should be responsible for continuing education courses and certification of practitioners.) Physician participation should be on a routine part-time basis. The practitioners should do all the physical assessments and return problems for the physician to follow through. The practitioners and nursing staff should be able to provide minimum life support treatment with arrangements to transport patients to the nearby hospital for prolonged treatment. The practitioners should be allowed to treat uncomplicated problems, following physician's standing orders. Physician extenders should also be consulted and agree with standing orders. Referrals to private physicians and private clinics should be followed by an appointed nurse and social worker to provide maximum care and insure complete follow up of patients, thus insuring continuity of care. Management should be under a supervising physician and nursing supervisor for the medical staff aids. Accounting and clerical should be under a separate staff with an over-all fiscal manager.

4. What type of certification process should be used for the providers whose

services would be reimbursed under this legislation?

The clinic itself should meet certification requirements (similar to those of an ambulatory Health Care Center). The practitioners should be from accredited schools and should be certified. The testing for certification should be commensurate with the undertakings of the responsibilities. (Accredited PNA and NP schools should be responsible for continuing education courses and certification of practitioners).

Sincerely,

MARY LOU CAMBERT, R.N., Pediatric Nurse Associate.

Jefferson Comprehensive Care Center, Inc., Pine Bluff, Ark., March 16, 1977.

Hon. Dick Clark, Senator, Senate Rural Development Subcommittee, 404 Russell Bldg., Washington, D.C.

Dear Senator Clark: Your letter dated March 7, 1977, was received regarding S. 708, a bill to permit Medicare reimbursement to rural health clinics for primary health services provided by Physician Assistants and/or Nurse Practitioners. We are a Community Health Center with a rural health clinic funded under Public Law 94-63, Section 330 and an RHI grant. We are vitally inter-

ested in your bill and have so informed Senator Dale Bumpers and Senator John L. McClellan of our interest and need for their support.

The following points and interests are submitted in support of the Senate

Bill 708:

(a) Authorization to use health care extenders (Physician Assistants and Nurse Practitioners) without immediate in-house physician supervision would permit us to maintain a five-day week operation rather than the current two-day per week physician covered program. Secondly, S. 708 would permit us to open two (2) additional rural health clinics in areas currently determined to be medically underserved by DHEW Secretary. The thirty-thousand rural citizens of this county would then have ready access to quality care within their respective communities, once the S. 708 was a law. The three rural communities each would serve approximately 7,000 to 10,000 each. When one sees the multiplier effort this would have on the United States rural communities and their need for health services, one wonders why we have waited to move in this direction.

(b) The opening of rural community health clinics with Physician Extenders properly and periodically supervised by a Physician over-seer, would eliminate a big barrier for many rural citizens and that is transportation. The ready access and availability of health services is a primary concern of the health planner and developer. The getting to and from services and the long wait to be seen by a physician could be grossly reduced by having a rural health center

within the community.

(c) The use of Physician Extenders should be a positive step forward in cost entertainment, especially in the provision of health services to the rural community. Charges or fees as related to actual cost for the service should show

a marked reduction compared to current health care costs.

(d) The Physician Extender — Physician Supervisor team concept should improve the continuity of care for the rural citizen in that greater access to services would be improved. Greater availability should permit greater opportunity for preventative care rather than what most rural citizens currently receive in acute care.

(e) The Physician Extender authorization would permit our program to use already qualified Nurse Practitioners in the delivery of health services rather than all Title XVIII and XIX patients having to be seen by the Physician thus limiting the number of patients we can see per day according to need. The Extender authorization would permit better use of the health care pro-

fessional.

(f) The primary concern of the community health center and their Rural Health Initiative Clinics is to address the needs of the medically underserved which more often represents the poor and near-poor. The Community Center is to maximize their efforts to secure reimbursement for services rendered in order to achieve some self-sufficiency. Under current regulation for Titles XVIII and XIX, reimbursement when confined to one provider level constitutes

a real barrier in achieving any degree of self-sustaining effort.

The several efforts to relieve the Physician shortage, such as National Health Service Corp, new Medical Schools, greater emphasis on Family Care Physicians and other carrots have grossly failed to bring the physician to rural America, especially here in the South. The Physician Extender approach may well be the only solution to no care or limited care for the rural citizen. Reimbursement by the Federal programs for Medicare and Medicaid patients rendered by accessible Physician Extenders and the Federal sponsoring for training and certification of the same Physician Extenders may well be an answer to the manpower shortage. This training and certification program should be viewed prior to National Health Insurance if rural America is to benefit from such a social effort. The Federal Government spends billions of dollars over the long-haul on physician training and yet the equal distribution of the byproducts of the system still confine their services in the urban areas. Should not all America benefit from such expenditure of tax dollars? It appears the leadership for the provision of rural health care may well rest in your committee on Rural Development. The ready access to adequate and appropriate health care by the rural citizen is just as important as the Federally sponsored programs in education, electricity, housing and/or flood control. The "Right to Health" precedes the "Right to Read".

Regarding requirements of the rural health clinic, the enclosed information under the Social Security Act as amended, out-lines the concept of the program as we try to manage the local program.

I personally feel a Federal guide should be developed for minimum standards for certification by the several states to use in granting such status to the

Physician Assistant and/or Nurse Practitioner.

The Arkansas General Assembly, (both Houses have passed) Senate Bill 264, addresess the authorization of the Physician Assistant and Nurse Practitioner but as yet, the Governor had not signed the bill into law.

We earnestly support your efforts and the co-sponsors of S. 708. If we can be of further assistance, please call on us.

Sincerely.

JOE H. SWEATT, Project Administrator.

Enclosure.

REQUIREMENTS OF A COMMUNITY HEALTH CLINIC

The Social Security Act is amended by adding after section 1861(z), (42)

U.S.C. 1395x(z)), the following new subsections: (aa), (bb).

"(aa) The term 'community health clinic' means an entity which is organized, equipped and staffed to provide, by and under the supervision of physicians, primary health services, and such preventive health services and supplementary health services necessary to support adequate delivery of health care; and that:

(1) employs the services of one or more physicians, who are supported to the maximum extent practicable by physician extenders, nurses and allied health personnel (in accordance with the health care delivery procedures prescribed

in subsection (A)); and

(2) is not part of a hospital, but is organized and operated (in the manner prescribed in subsection (B)) by a nonprofit private corporation or public agency to provide health and medical care to outpatients, and which vests general policy making responsibility in a governing board of which at least a majority (of members) are local residents and consumers of community health clinic services.

(A) Community health clinic services, as defined in section (bb) of this Act, shall be rendered in compliance with the following health care delivery

standards.

(1) The patient care policies of a community health clinic are developed with the advice of a committee of professional personnel, including one or more physicians, one or more registered nurses, and (if dental care is provided) one or more dentists, with provision for review of these policies from time to time by the patient care advisory committee. A community health clinic shall have a medical director, a nursing director, and (if dental care is provided) a dental director responsible respectively for implementing medical, nursing and dental care policies established by the patient care advisory committee.

(2) A community health clinic has on its staff one or more physicians authorized to practice as a geriatric specialist, a family practice specialist, an internist, a pediatrician, or exclusively as a general practitioner. The health care services and medical care services provided to any patient treated by a com-

munity health clinic are rendered under the supervision of a physician.

(3) A community health clinic providing the health care services of nurses has one or more registered nurses on duty during normal operating hours to

render nursing care and to supervise the nursing services offered.

(4) A community health clinic providing the services of physician extenders, by whatever title they may use by law or practice, does so in accordance with appropriate state law and consistent with sound medical practice which governs the utilization of nurse practitioners, physician's assistants, nurse clinicians, physician's associates and other individuals who are specially trained to work under the supervision of a physician in performing specific medical care and health care procedure ordinarily otherwise reserved to performance exclusively by a physician.

(5) The medical care and health care practitioners utilized by a community health clinic participate in an ongoing quality assurance program set up by the patient care advisory committee or the appropriate regional professional standards review organization or both, which may include peer review, chart review, comparative patterns of practice review and continuing education.

(B) Whether organized and operated by a nonprofit private corporation or a public agency, a community health clinic shall be structured to funtion in

the following manner administratively.

(1) The governing board of a community health clinic is a local group with at least a majority of its membership being lay consumers of community health clinic services, and no more than a minority of its membership representing persons practicing vocations and professions in the direct delivery of community health clinic services.

In order to assure that standard operating policies and procedures are

adequate to support established patient care policy.

(2) The governing board of a community health clinic formulates, reviews

and approves general operating policies including, but not limited to:

(i) personnel policies affecting hiring standards, work rules and employment benefits: and

(ii) patient admission policies and procedures on fees and billings; and

(iii) procedures for maintaining a unified and confidential medical record for each patient treated; and

(iv) procedures for the storage, administration and dispensing of drugs and biologicals in accordance with sound medical discretion and applicable state

and federal law; and

(v) procedures for maintaining the health and safety of facilities and equipment used by a community health clinic, through compliance with reasonable rules established by the appropriate state authorities to prevent unreasonable patient and staff exposure to fire hazards, to harmful radiation, and to communicable and reportable diseases;

(3) The governing board of a community health clinic reviews allocation of the institution's financial resources and approves the clinic's prospective an-

nual budget.

(4) The governing board of a community health clinic contracts for the services of health and medical care practitioners necessary to implement patient care policy, and for the services of administrative personnel as deemed by the board to be necessary to implement general policy and conduct day to day operation of the institution, and for other services as deemed necessary by the Secretary to assure the legal, medical and fiscal viability of the community health clinic."

COMMUNITY HEALTH CLINIC SERVICES

"(bb) (For the purpose of understanding the characteristics and limitations of services rendered by community health clinics, as defined by section (aa) of this Act) the term 'community health clinic services' refers to activities and procedures inherent in each of the following three types of health care (as described in subsections (A), (B), and (C)).

(A) 'Primary health services' mean:

(1) comprehensive diagnostic, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the supervision of a phy-

sician or a dentist (if dental care is provided); and

(2) a broad range of medically appropriate diagnostic tests or services, including without limitations x-rays and electrocardigrams, rendered through the laboratory facilities of a community health clinic or through reasonable access to appropriate facilities.
(B) 'Preventive health services' mean:

(1) individual and family education and counseling, and group education and counseling in community and industrial health education programs; and

(2) immunizations, periodic screening and diagnostic services furnished to well-patients in accordance with accepted medical practice, and which place particular emphasis on providing regular checkups for expectant mothers, newly born infants, children and adolescents to prevent abnormal development and disease.

(C) 'Supplementary health services' mean:

(1) appropriate referrals to practitioners of recognized medical specialties; and

(2) arrangements to provide reasonable access to the services of a general hospital; and

(3) arrangements to provide reasonable access to health care services in case of medical emergency, emotional disturbance or mental illness; and

(4) to the extent feasible, arrangements with home health agencies and

(1) to the extent reasine, arrangements with nome health agencies and custodial care institutions to provide reasonable access to the services of these agencies when patients can no longer be treated on an ambulatory basis; and (5) other ancillary programs, from time to time, that are developed and deemed necessary by the governing board of the community health clinic to supplement the outpatient care rendered by the institution such as, but not limited to, a transportation program, a medical services program, a patient subtracts program." outreach program.'

> SCHUYLER HOSPITAL, Montour Falls, N.Y., March 23, 1977.

Mr. DICK CLARK. Chairman, Senate Rural Development Succommittee 404 Russell Bldg., Washington, D.C.

DEAR MR. CHAIRMAN: The Schuyler Hospital Primary Care Program in Montour Falls, New York is located in a medically underserved section of Appalachia. This program was initially funded by Appalachian Regional Commission and one of the five physicians is a National Health Service Corp Physician. This program has become self-sufficient and is able to expand its

medical services with a Health Underserved Rural Areas Grant.

Without Medicare reimbursement or grant funds, it is doubtful that this community will be able to retain both the Nurse Practitioner and Physician's Assistant. In a rural area there are not any extraneous funds available to support their salaries and expenses if they cannot generate enough funds through patient or third party reimbursement. Many Medicare patients explicity request the physician extenders. Our physician extenders make home visits. They can contact a physician by telephone or by car radio. However, at the present time, we cannot bill for these medical services which in many cases saves Medicare from having to pay for hospitalization or emergency care. The Schuyler Hospital Primary Care Program is currently trying to participate in the University of California Medicare Physician Extender Reimbursement program. However, we were almost excluded from this study because we are hospital based and bill Medicare Part A.

In exchange for Medicare funding of physician extenders, I think controls

should be established as proposed:

(1) All patients seen by the Physician Extender should have a written record of the visit reviewed and countersigned by the physician within one working day of the visit.

(2) The physician and the physician extender should be jointly responsible for malpractice liability. The physician should always be available for the physician extender by telephone, radio, or physically present in the office.

(3) The Physician Extender should have successfully passed the National Certifying Examination given by the National Board of Medical Examiners, and they should be registered with their respective states or D.H.E.W. before they can receive Medicare reimbursement. Every two years, it should be required that they become recertified to continue to receive Medicare reimbursement. Recertification should be contingent upon proof of a minimum of 100 hours of continuing medical education.

Medicare reimbursement for physician extender medical services can be a tremendous asset to the rural community when coupled with the proper manage-

I hope my views have been of assistance. If you have any questions, please call me 607-535-7157.

Sincerely,

MRS. PAT B. WHITT. Assistant Administrator, Schuyler Hospital.

STATEMENT OF JOHN DOYLE ELLIOTT, SECRETARY, TOWNSEND FOUNDATION

Mr. Chairman: The Townsend Plan Movement fully endorses Senate Bill 708 as being inherently embraced in this movement's objectives and convictions. Since 1947, we have counseled complete federal health-insurance. Decades late, in our opinion, Congress now faces this issue because private insurance (plus local and States' governments' authorities have unanswerably failed to do the job — because they can't! Nothing else, or less than complete federal insurance directly vested in ALL the people can financially authorize the medical profession (along with the relevant industry, labor, business and science) to solve this problem as it could and ought to have been solved in this land very long ago.

These objectives and convictions, basic to the Townsend Plan, specifically include the purposes, completely, of S. 708, as regards health-maintenance and

treatment in rural and small communities.

In our view, the very existence of areas and communities in our country which, in terms of their own resources, can't finance fully competent and complete health-service — that reality is no reason for not instituting public insurance to assure complete health-service in such places. In honest truth, that reality is unanswerable reason why S. 708 ought to be passed — in justice, it ought to have been part of Medicare from the very start!

Incidentally, Mr. Chairman, this is an emphatic example of the correctness of the Townsend Plan's principle that all the people — in respect to prosperity-sharing retirement, disability-insurance and complete health-insurance — should be and can be equally and fully insured by the Federal authority.

Prosperity-sharing Social Security benefits and complete health-insurance are essential to the honest human prosperity (the only possible basis for freedom with justice) which ought to dominate human life in our land — honest prosperity, the thing upon which depends our ability best to afford all other things!

Submitted herewith are copies of our previous testimony and of our advices to Congress respecting the genuine solution of the problems embraced in social security and health-insurance — for the interest and use of the Sub-

committee.

Also submitted is copy of H.R. 3063, the Pay-As-You Go Social Security, Prosperity and Health Insurance Act, introduced by Rep. John J. McFall, Sec. 4 (page 36) of H.R. 3063 specifically defines and provides for complete finance of complete, life-long health-insurance for the total, legal population of the United States — no bills to patients — recommended overwhelmingly by the last, 1971 White House Conference on Aging and, so far, virtually ignored by Congress.

Congress has, in fact, tended to move the other way — via deductions, premiums, co-insurances etc. (really taxes in disguise) — not to perfect Medi-

care's insurance of the people; but, to un-insure them!

Mr. Chairman, it is the problems — not the cures — that we can't afford! It's not that we have too much just Social Security — but, too little! Not too much health-insurance, but too little! Every injustice and lack in these areas of socal justice — no matter who may fancy gain therefrom — every one of them, in history's balance of the books — is loss, failure, destruction, injury — loss not profit!

We heartily joint Senator Clark and his Co-sponsors in support of Senate

Bill 708.

SEPTEMBER 24, 1976.

Mr. Chairman: Mounting confusion reigns between honest realities and the prevailing debate in Congress on Social Security benefits and their funding. Fewer workers supporting more retirees — ballooning budgets, skyrocketing taxes etc.. etc. They all are based on excuseless unconcern for realities and/or conscious aims to perpetuate social injustice in deference to limited, brutal interests.

The truth. If prosperity-sharing — not impoverishing — retirement and disability benefits, with complete health insurance, were living facts of life for all our people — (whether by public of private policies — or both) the economic, financial impacts of such benefits would be exactly the same. The only real

question is:

"Is social security good, or bad?" Its purpose is to remedy admitted flaws in our honest prosperity, on which depends our ability to afford all other things! The problem is because of our misfortuned, not because of the well-fortuned. The problem's not too much social security — the problem's too little! What we can't afford is the problem — not the cure!

Present social security should be repealed (as were the Public Assistance titles after 38 years of defensless injustice and misery) — as a brutal failure

progressively compounded by continuance. All our other glories stand mocked

by this Humanity-punishing failure. Two courses are open.

First, replacement by the prosperity-sharing retirement and disability insurance provided in H.R. 2910 — the "Pay-As-You-Go Social Security and Prosperity Insurance Act," the up-dated Townsend Plan Bill, providing all beneficiaries (even those caught with no other resource) up-to-date participation in prevailing standards of income and living.

Second, amend the present system by vesting in all individuals a "presumed wage in covered employment", initially providing benefits sufficient to bar eligibility for Supplemental Security Income benefits. Quarterly, raise this "presumed wage" to provide, in two years' operation, prosperity-sharing participation in prevailing standards of income and living as the minimum Social

Security benefit.

Thus, in either case, we'll have all our people insured equally by the same non-discriminating system. Nothing less can spell justice. Only so, can we fully honor justice — and reduce administrative costs to full-value-for-money-spent levels.

Medicare should automatically vest in all beneficiaries. It, then, should expand immediately towards including all prescribeable treatment, care and supply (including health maintenance). No bills to patients. So perfected, in experienced operation, it should rapidly expand to cover all our people through-

out their lives.

Finance the "presumed wage", all Social Security benefits, completed Medicare and national health insurance by the general-revenue tax defined and provided in H.R. 2910 (Sections 214 and 229 of the first section), to render the financial impacts of the whole system justly progressive — not punishingly re-

gressive, as now.

Mr. Chairman: History will audit as loss, not profit, every injustice and wrong to mankind — no matter who may fancy profit therefrom. Every last, evil one of them is an injury, injustice, destruction — loss — not profit. Human life, health, just freedom — those are the essentials for happiness successfully pursued. They are the justifications — value — of all honest, economic things and acts.

Their lack measures our failures, loss — if continued, disaster, Mr. Chairman, the above reforms are, in this Country, 35 years overdue.

MARCH 29, 1976.

We must perfect social security — or perpetuate the losses of recessions. These losses are irrecoverable. The time of unemployed lives is gone, lost, forever.

Argument-crushing reality. Without Social Security benefits — drastically inadequate as they are — this recession would be vastly more severe. Equally clear: If such benefits had existed in the late 20's and early 30's, they would mightily have eased the Great Depression and beneficially altered history — even though they're hardly a good shadow of what they ought to be. That's the truth.

Self-evidently, now, for all to see, we have recessions not because of too much social security, but because of too little. The cure is perfected social security:

To end recessions, we need prosperity-sharing not impoverishing retirement—plus complete health insurance for all aged and disabled—for our country to be the noble house of freedom-with-justice it should be. There is no good reason — only bad ones — for living standards in retirement being inferior to those of any other time of life.

The alternative is continued destruction of life, liberty and the successful pursuit of happiness — with economic failure and dependency persisting as life's brutal, final reward for multitudes — excuselessly dictating on-going failure by our country to achieve its deserved glory and respect in the World-

wide eyes of Mankind.

What a spectacle. Our Bicentennial Anniversary with responsible leaderships proclaiming, electioneering, that we must limit, sacrifice "social expenditures" in favor of defense — that "we can't have both butter and guns". The truth is that on our honest, just, human prosperity depends our best ability to afford all other things! Either we see to our "butter" — or, we're on the swiftest road to "gunless"! The Pentagon ought to be Social Security's foremost champion!

What a spectacle — our responsible leaderships telling us we can't afford the cure — when, plainly, what we can't afford is the problem! There's the truth.

No matter what may be our success in all other things, economic failure and dependency, as the punishing, final reward in life for our people, bitterly mocks all other glories. This has always been this Lobby's proud, keystone conviction.

In this light, we are proud again to have presented the ways and means for the whole establishment of perfected social security and national health insurance — embodied in H.H. 2910, the "Pay-As-You-Go Social Security and Prosperity Insurance Act" (the updated application of the principles of the Townsend Plan to the problems of social security and unjust poverty) — introduced by Rep. John J. McFall.

Conclusion. Now is the best time to perfect Social Security benefits and Medicare — to the ends of reinforcing recovery and future recession-prevention. Let this truth be clear: If a need's actually met — a job actually done —

publicly or privately — if actually done, it equally in the economy.

Let us no longer fear public programs which alone can remedy admitted flaws in our honest prosperity — like Social Security and health insurance. Importantly, they alone can strengthen us as we mightly need to be strengthened.

Their lack is our real weakness. Regardless of all other successes combined, their lack renders recessions inevitable.

JANUARY 27, 1976.

SPLIT THE BUDGET - OR NEVER "REFORM" TAXATION

Tax "reform" is an endless exercise by Congress. Furor over unjust taxes constantly re-arises — with "reformed" taxes no better than those before them.

This Lobby discerns a runious fallacy underlying this brutal, economic dilemma and herewith undertakes its clarification and solution. Continued unjust taxes — whoever fancies profit from them— dictate loss, not profit, for our Country and for Mankind, in the final balance of history's books. It's self-evident that every injustice and wrong is a loss, a destruction and injury — not a profit.

The fallacy is the prevailing assumption — perhaps justified in the long-ago—that taxes are, *ipso facto*, a loss, cost and burden to our society and citizens. Taxes to finance public works and various projects, programs and services which inherently require consumption of manpower, resources and money — thereby denying them to the support of life, honest prosperity, freedom and happiness — those taxes are economic costs, burdens and limitations. They are Society's public overhead.

However, we also have public projects and services — Social Security and health insurance, for example — to remedy admitted flaws in our honest prosperity. Let none forget that on our honest prosperity depends our best ability to afford all other things. These perfections of honest prosperity are bene-

fits, not burdens.

Our thesis is simple. The same tax-impact can't be right for both benefits and burdens; an obvious, self-evident truth. Benefits are of progressively greater value to the financially misfortuned than to the successful. To the affluent, they are insignificant. Burdens and benefits require opposite tax-impacts

The real answer. All public budgets — federal, state and local — must be cleanly split between burdens and benefits. For burdens there must be progressively rated taxes honoring ability-to-pay — equality-of-sacrifice — on the net income of all persons and companies without exceptions or distinctions

and clearly known to all.

For benefits — in themselves clearly progressive — there must be flat-rate taxes proportionately the same for all, on the gross income (gross receipts) of all persons and companies — as specified in sections 214 and 229 of the lrst section of H.R. 2910, the 'Pay-As-You-Go Social Security and Prosperity Insurance Act'.

Only these two principles, universalized identically for all throughout our entire economic structure — based on the clean division of budgets between

benefits and burdens - can establish premanently just taxation. Their lack

measures our prosperity's flaws — their presence our future abilities.

This totally generalized, completely uniform tax-system will preclude honest need for tax-exceptions, tax-incentives, etc.—because in each area of competition every competitor will be in the same position tax-wise. Without this honest, clear-to-all tax-system (be they big or small, mighty or common) — without it our ability to meet History's demands on us, to afford the future as we should, will be weakened, flawed!

Can there be a finer tribute to our Bicentennial than full, just maturity of

our social-benefit system coupled to full, permanent "reform" of taxation?!

DECATUR COUNTY HEALTH COORDINATING COUNCIL, INC.
Oberlin, Kans., March 21, 1977.

Hon. DICK CLARK, U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: On behalf of the Decatur County Health Coordinating Council, Inc., I am writing in regards to Senate Bill 708, a bill to amend title XVIII of the Social Security Act to provide payment for rural health clinic services. The Council wishes to express its support for Senate Bill 708 as it totally agrees with the concept and, to assure quality care as well as accessibility of care, agrees with the criteria set forth for a clinic to qualify for medicare reimbursement.

On July 1, 1976, the Council was fortunate enough to be awarded a "Health Underserved Rural Areas" Grant from the Department of Health, Education, and Welfare (DHEW). This is a grant program in support of demonstration and research in the delivery and financing of health care services in Health Underserved Rural Areas (HURA). The program is authorized and funded under Section 1110, Title XIX (Medicaid) of the Social Security Act as

amended in 1965.

As outlined in the attached "Prospectus For Health Underserved Rural Area Grants-January 1976", DHEW,¹ one of the goals (Page 1 of the "Prospectus") is to "demonstrate the contribution of non-physician providers to the financial stability and professional attractiveness of complete rural health systems". One of the objectives (page 3 of the "Prospectus") is "to demonstrate methods for the utilization and financing of personnel (physician extenders, clinical pharmacists, nutritionists, therapists, etc.) as well as technology (e.g., telecommunications, transportation) for them in rural primary care settings that can contribute to increased services. . .". On the one hand, we are encouraged by DHEW to utilize the services of physician extenders, yet, on the other hand, these services will not be reimbursed by the Medicare or Medicaid programs. This in turn eliminates the financial support/stability required to establish rural health clinics through the use of physician extenders.

Part of our HURA grant is to set-up two satellite clinics in FY-77 and four more clinics in FY-78 to be staffed by physician extenders. With 30% of our county's population being 65 years old and over, the financial feasibility and existence of these clinics beyond our grant period (June, 1979) is doubtful un-

less Senate Bill 708 is passed.

At the present time, Decatur County has one physician for a population of 5,000 and an approximate service area of 6,000. In order to allow our population accessibility into the rural health care system in a timely manner, the utilization of physician extenders and satellite clinics is a must. The people of this proud, progressive, agricultural rural community/county have actively sought ways to provide an adequate and complete health care system through innovative ideas and hard work. The HURA grant has enabled us to more aggressively pursue this endeavor through 1979, but it is the intent of all concerned that the health care system will be self-supporting at that time without the further need of federal funds. Passage of Senate Bill 708 will greatly aid the reality of this goal.

Sincerely,

G. R. ADDLEMAN, M.H.A., Executive Director.

¹ Retained in files.

MUSCATINE COMMUNITY HEALTH CENTER, Muscatine, Iowa, March 18, 1977.

Mr. Dick Clark, Chairman, Senate Rural Development Subcommittee, Washington, D.C.

DEAR SENATOR CLARK: Thank you for providing me with copies of Senate Bill 708 which provides for Medicare reimbursement for primary health services provided by nurse practitioners and physician assistants in rural clinics. After careful review of the bill, and discussions with physician assistants at the Muscatine Community Health Center, I would submit the following comments: (1) It is our feeling that reimbursement for services should be based on a usual, customary, and reasonable fee for service rather than on a cost basis. We do not feel that reimbursement on the basis of cost provides any incentive for the provider to reduce the cost of his operation, as a matter of fact — the higher his cost, the higher his reimbursement. It would also seem that the mechanics of reimbursement would be facilitated if the physician extender were reimbursed on the same basis as the physician. (2) It does not appear that legislation of this sort would assist the small communities in the Muscatine area and would be of value to only ten counties in Iowa and portions of sixty-one other counties in which there are pockets af medically underserved persons, according to existing criterion. Within the Iowa Heauth Systems Area only one census tract in Northern Scott County would qualify. It is our feeling that no attempt should be made to restrict the provisions of this act to rural clinics. There are certainly medically underserved areas in the inner-city and even in communities the size of Davenport and Cedar Rapids, Iowa. There are also patients restricted to nursing homes who do not receive physician care and treatment, whom the physician extender should be permitted, encouraged and reimbursed for treating. (3) It is our understanding that Iowa requires the physician to spend two, one-half days each week in the satellite clinic supervising the physician extender. We feel that this is a good requirement. We also feel that all patient charts maintained by the physician extender should be reviewed periodically by the physician with written evidence to support such review. (4) We feel that all patients requiring hospitalization should be admitted by the supervising physician. (5) As a condition of licensure of the physician extender in the State of Iowa, the State Board of Medical Examiners requires that the supervising physician list the specific procedures and functions and the estimated annual number of such procedures and functions which the physician extender will be licensed to perform. We feel this requirement is justified. (6) The standards for certification and recertification of physician assistants by the National Commission on Certification of the Physician's Assistants seems to ensure an adequate certification process.

Thank you for the opportunity to comment on the proposed legislation; we are most pleased with the work that you are doing in promoting an improved

health care delivery system.

Sincerely,

E. W. Colbert,
Muscatine Community Health Center.

STATEMENT OF WILMA NICHOLSON, R.N., LARRY PAGETT, CHAIRMAN-TRUSTEE, SOS HEALTH CENTER, SEELY LAKE, MONT.

The Seeley Lake-Swan Valley Hospital District DBA as the S O S Health Center has been in operation for the past six years servicing a 90 mile stretch of Montana's logging, ranching and resort areas that extends into three counties, Missoula, Powell and Lake.

The Health Center is the primary source of health care services to all age groups and encompasses all services, home care to the elderly, emergency services, all school services to three schools, screening clinics and referral treatments from physicians, of which the nearest is 60 miles distant in Missoula.

which is also the base of the nearest hospital.

We are located in a mountain valley which is frequently isolated by abundant snowfall and treacherous road conditions and further complicated by the fact that there is no public transportation to or from the area which makes mobility for the elderly even more difficult.

The Health Center is staffed by a well qualified community health nurse that prides herself in the fact that almost all of the elderly in the community she serves, are able to remain at home due to the quality of home health care services she is able to provide even to those chronically ill and bedridden with severe debiliative diseases.

These services at present are being paid to the nurse by Medicaid, Workmen's Compensation. AARP and many other private insurance carriers. In fact, in the past six months "Skilled Nurse Facility" has been listed as a provider

on some of the insurance forms we have received.

Medicare payments have been paid to the Center for emergency transports of the elderly with conditions such as, G.I. bleeding, fractured hip, fractured femur and heart attack. And so it seems unreasonable that preventative health services and treatment such as blood pressure checks, suture removal, dressing changes, simple lab work and nutritional information which can be a severe problem with the elderly, combined with the isolation and the loneliness in a community such as ours, is not being paid by Medicare.

The Center also provides field experience in community health for student nurses from the Montana State University at Bozeman and gives them the rare opportunity to see a well trained nurse using all her capabilities to the fullest extent in a rural health setting and should be reimbursed by Medi-

care funds for their services.

My time to get this to your desk is short. I feel confident that you will support this bill as the need in rural health areas is critical and many guidelines for assistance are so stringent.

TUSCARAWAS COUNTY GENERAL HEALTH DISTRICT, Dover, Ohio, March 18, 1977.

DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. HARF: I would like to make the following comments regarding health services provided by Nurse Practitioners and Physician's Assistants,

which will be discussed in Senate Bill 708.

Our five year Maternal and Child Health grant, through an Appalachian Region Commission demonstrating use of physician extenders has terminated February 28, 1977. Over a five year period we saw 11,709 patients and made 9,238 referrals for defects found. Our clinic is staffed by two Pediatric Nurse Associates and one Family Nurse Practitioner under the supervision of a physician. During the first year of operation, a physician was on premises for three days a week, his time on premises was gradually phased out as the physician extenders gained experience. From the fourth year of operation the physician has been off premises and available for consultations, supervision and emergencies only. This is a very adequate and acceptable arrangement.

During our five year operation we have absorbed a large population of the Medicaid eligible patient due to local physician shortage and refusal of the private physician to accept Medicaid/Medicare patients. With our grant money ending and no reimbursement from Medicaid/Medicare, we are facing closing our doors and leaving the patient without medical care; especially preventive care. We are the only health facility in a three county area; Tuscarawas, Carroll, and Harrison, providing any large scale primary health services and preventive health care. It is a crime that our proven systems, as many others is facing financial crises without Medicaid/Medicare reimbursement.

Reimbursement for services of the Nurse Practitioner and Physician's Assistants should be made through a provider number to any agency or physician, meeting the criteria of the Rural Health Clinic Bill, for providing primary health care. A Physician's Assistant under law can only function under contract to a physician so he must be affiliated with a physician for reimbursement. There is a movement for Nurse Practitioners to establish independent practices. I feel, as a Nurse Practitioner, this is not desirable and these practitioners should not be eligible for reimbursement as independent practitioners. Nurse Practitioners should not be given their own provider numbers.

After a year's preceptorship, the Nurse Practitioner can function with a physician available on call for consultation, interpretation of diagnostic

studies, and regular review of services rendered. Before a Nurse Practitioner or Physician's Assistant begins practice, the physician extender and physician confer and agree on standing orders to cover scope of practice along with arrangements for referral. The referral arrangements should be made to the best available medical care. These referrals will vary greatly from area to area. Emergency and acute care are always in question. One must first constitute what is an emergency. I define it as any immediate threat to life. The realm of practice of Primary Care facilities constitutes giving immediate life support assistance to the patient and transporting to an emergency facility. All nurses and Physician's Assistants and many para professionals are trained in emergency life support.

This leaves only one question in the role of physician extender in dealing with emergencies; that being the need for a formal arrangement with a facility to receive emergency patients. Under standing orders the physician extenders can and do treat usual and uncomplicated illness. This reflects that a physician does not need be on premises. There can be no cut and dried policy for reimbursement in the areas of physician participation, arrangements for referral and management policies. Generally speaking, arrangements for referral are dictated by resources available, but patient should be referred to the best source available. Management policies must encompass all the minimum stand-

ards as stated in this bill and be in writing by the agency.

Certification is an excellent thing but I believe we must certify the education programs that prepare Nurse Practitioners and Physician's Assistants first. There are numerous programs across the country but there is little unity in curriculum, length of training time, etc.

Sincerely,

MARCIA MURRAY, R.N., Family Nurse Practitioner.

Petersburg City Health Department, Petersburg, Va., March 23, 1977.

DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. HARF: Thank you for the opportunity to comment on the Rural Health Clinic Bill S. 708. My comments are those of a Health Director for one District in the State of Virginia Health Department system. This District in-

cludes five rural counties in addition to several cities.

The experience of this District confirms the impression that medical resources tend to cluster in and around the cities. Rural counties are in need of medical resources. Physician extenders appear to be a human resource that holds promise for improving and increasing the delivery of primary care services to rural areas. The development of this resource requires a degree of funding reliability. The prospect of Medicare payment for services provided by physician extenders, as proposed in S. 708 would contribute significantly.

The category of physician extenders employed by the Health Department is the Family Nurse Practitioner. Two levels of professional qualifications are recognized. The Family Nurse Practitioner with basic training and experience customarily provides clinical services in company with a physician but may work apart in certain specified situations. The Family Nurse Practitioner with advanced training and experience is judged capable of providing a range of clinical services without a physician being physically present. For both categories, protocols and physician supervision and review assure the appropriateness and quality of input. In addition, access to a physician is assured at all times.

The wording of the proposed language of S. 708 is consistent with Health Department policies and our experience. The passage of this proposed legislation would facilitate our efforts in attempting to bring needed primary services to rural areas.

Sincerely.

John R. Tietjen, M.D., Health Director, Crater Health District, CHAMPLAIN VALLEY AREA AGENCY ON AGING AND NUTRITION PROJECT FOR THE ELDERLY, South Burlington, Vt., March 23, 1977.

DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. HARF: I wish to submit the following statements in support of S. 708, a bill to amend Title XVIII of the Social Security Act to provide payment

for rural health clinic services.

Access to low cost health services for elderly persons is an area of prime concern to this agency. Currently transportation to doctors, clinics and hospitals is our highest priority for transportation services and approximately 40% of our transportation is to these facilities. We also allocate 22% of our Title III service dollars to reimburse local Home Health Agencies for nonreimbursable costs for homemaker-home health aid services. In this region much time and energy has gone into developing a health delivery system which makes sense in rural areas. These efforts have been continuously frustrated by federal reimbursement regulations.

The experience of the Champlain Islands Center submitted by Senator Patrick Leahy and published in the Congressional Record on February 10, 1977 demonstrates local problems in trying to deliver reasonable access to health services in sparsely settled areas. We also wish to support other statements published in the Record relating to the scarcity of country doctors, rural populations which are too small to support a full-time physician, and the need for rural clinics which can provide referrals and follow-up and pri-

mary care as the first step in a health delivery system.

This agency strongly supports the passage of S. 708 which would allow rural health clinics to be reimbursed for primary care and treatment delivered by nurse practioners and physician assistants under the general supervision of a physician.

Sincerely,

MARY ELLEN SPENCER, Director, Champlain Valley Area Agency on Aging.

STATEMENT OF JAY CONNOLLY, CHAIRMAN, JOINT COMMITTEE OF SENIOR CITIZENS' ORGANIZATIONS, HEMPSTEAD, N.Y.

I am Jay Connolly, Chairman of the Joint Committee of Senior Citizens' Organization (of Long Island, N.Y.) and Vice President of the New York StateWide Senior Action Council. Today, March 29, I am attending a special Executive Committee meeting of StateWide in Utica, N.Y.

I am heartly in favor of S 708, the bill to amend Title XVIII of the Social

Security Act to provide payment for rural health clinic services.

Although I am a resident of a suburban village and a suburban county, I am aware of the dire need to improve medical service for Rural America. As a firm believer in providing proper health care for all citizens — and as equally as possible - I urge approval of S 708.

There should be no doubt that preventive medicine can be one of the most important, if not the most important, factors in the health and welfare of the

American citizen.

Due to the constant attrition of physicians in rural areas, there is an urgent requirement for suitable medical care to handle the seriously ill and also to attend to the less seriously ailing in the population.

Small primary care clinics provide the answer for the ill of Rural America. They should be staffed by a competent primary care provider with back-up supervision by a physician. They should be supported by Medicare funds.

The aged, handicapped and ill in Rural America are denied the health care they need because Medicare now prohibits reimbursement to nurse practitioners and other physician extenders unless a doctor is physically on site.

Without reform of Medicare to compensate clinics adequately for the services they provide the ailing in Rural America, we will be sentencing hundreds of thousands of our citizens to unnecesary suffering and earlier, more painful deaths.

As, a retired businessman and as a senior citizen leader in Suburban America, I urge that equal and adequate medical care be given to my fellow citizens in Rural America and that Medicare reimburses the nurse practitioner and other physician extenders working under the general supervision of physicians.

P.S. — Although I am not representing them in this brief, I hold the following organization affiliations. Chairman, Legislative Advisory Committee for Nassau County's Senior Citizen Affairs Department, Title XX Advisory Council of Nassau County, Director of Senior Forum of Nassau County, Legislative Chairman of the Bi-County (Nassau and Suffolk) Alliance of Senior Citizen Clubs, Co-Chairperson, Nassau Action Coalition's State-Federal Task Force, and Vice President, Citizens for Nursing Home Reform.

DELTA/HILLS PUBLIC HEALTH DISTRICT, MISSISSIPPI STATE BOARD OF HEALTH DISTRICT OFFICE V, Greenwood, Miss.

Re Written testimony relative medicare reimbursement of rural health clinic services to be introduced at hearing scheduled for March 29, 1977.

Mr. David Harf, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. HARF: Thank you for the opportunity to comment and testify

relative Medicare reimbursement of rural health clinic services.

I have been involved with establishing a rural health service in West, Mississippi (Population-300; Service Area-15 Mile Radius of Clinic; Area Population-2800). This has been accomplished with a combination of funding: namely, Regional Medical Program, Rural Health Initiative, local and state public health dollars and local contributions. The clinic is attempting to provide services in an area where medical help is very limited and where poverty is high. This clinic is also attempting to demonstrate the utilization of an Adult Health Nurse Practitioner (first in the State of Mississippi) as a provider of health care in rural areas, as well as the entry point into the health care system.

Once our grants run out, it will be next to impossible for this clinic to obtain self-sustaining status as was projected, because the principal sources of income are Medicaid and Medicare reimbursements for services rendered to eligible clients. Currently, Medicare funds are being received only for Home Health services rendered, and Medicaid funds only on days when a physician

is present in the clinic (one afternoon a week).

The legislation proposed would assist this small community by making available third party reimbursement for services rendered by the practitioner in the absence of the physician. There is no way that physician manpower can be extended to rural areas of Mississippi such as West, other than through the Adult Health Nurse Practitioner and other nurse practitioners such as Certified Nurse Midwife, Pediatric Nurse Practitioners and Family Planning Nurse Practitioners. Their utilization in rural settings is dependent principally on physician/user acceptance and Title XVIII and Title XIX reimbursement for services rendered eligible clients.

Reimbursement for services provided by the Nurse Practitioner should be to the clinic in which she is an employee, and not directly to the Practitioner. I feel very strongly in this, because the Practitioner is authorized to practice medicine under the auspices of a physician (preceptor) and only in the supervised setting (regular review of activities, charts by preceptor) of a clinic. To reimburse them directly would lead to an independent practitioner functioning

outside of the supervised setting.

The clinic setting should be an organized service center (private, non-profit agency, public agency or private setting of the physician's office, or hospital outpatient setting), where the physician(s) would be responsible as preceptor for the services rendered by the practitioner, and be responsible for reviewing on a regular basis their activities. Further, the practitioner should have an established referral pattern for advancing patients through the health care sys-

tem to the most appropriate individual (agency) who can provide the needed service.

Lastly, the activities that the practitioner can perform for the patient should be clearly defined in a written policy and procedure book with standard protocol (manual identifying capabilities and limits of the practitioner). All of the

above are minimum in order for the clinic to fulfill in order to receive or qualify for reimbursement under Title XVIII, Title XIX and other Federal Programs.

The Nurse Practitioner, in order to be reimbursed must be certified by the appropriate Board (Nursing or Medical, or both) under the laws governing the state and these standards for certification should include graduation from a recognized and accredited training program for Nurse Practitioners, as well as any qualifying examination or review of credentials by the appropriate Licensing Board.

Sincerely yours,

ALFIO RAUSA, M.D., Health Officer, District V.

SHENANDOAH MEDICAL CLINIC, Shenandoah, Iowa, March 21, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. HARF: Thank you for your correspondence of March 7, 1977, on the subject of Medicare Reimbursement of Rural Clinic Services. As you are well aware, this is a matter in which I have great concern and interest. Legislation that would provide financial reimbursement for health services provided by nurse practitioners and physician's assistants without the presence of a physician would be invaluable to rural health care. As Senator Clark is well aware, physician shortage is acute in Southwestern Iowa. We have, in the Shenandoah area, attempted to alleviate the physician shortage problem by developing satellite clinics in both Farragut and Essex, Iowa. It certainly defeats the purpose of satellite clinics, which are manned by nurse practitioners or physician's assistants, to have to have the physician present supervising the extended care facility. We do make weekly visits to these clinics-two times weekly to Farragut and three times weekly to Essex. To have a physician constantly supervising a nurse practitioner or physician's assistant, certainly does not aid the manpower shortage that we are witnessing in our area. These are people who are well-trained and operate under a strict outline criteria established by the physicians in charge of the rural health clinic.

Reimbursement made for services provided by nurse practitioners and physician's assistants by Medicare and other health insurance programs should be forthcoming if the satellite clinics are to remain viable. These individuals are, as aforementioned, highly-trained people capable of making diagnosis or referring to physicians if the need arises. In our Essex Clinic, physician's participate actively in reviewing the physician's assistant's office calls daily. We "okay" each prescription that is written, arrangements for pharmacies to deliver medication to the Essex community on a daily basis are made, and arrangements through the base clinic are made for referral and management problems. Policies concerning management of specific care are outlined in detail in for medical directive booklet for the physician's assistant. He is to follow those directives concerning the majority of problems he will see in the office. For instance, if he sees an acute pustular pharyngitis or tonsillitis, his criteria for this diagnosis must be followed in the medical directive book and

his treatment must follow those given to him in our directive.

I feel, certification should be left to the individual states and their legislative bodies. It is my feeling here that within a reasonable time after graduating from a nurse practitioner's school or physician's assistants school, that certification would be mandatory for those individuals to be allowed to practice as physician extenders. Certainly, this is a requirement that must be met by all physicians and I see no reason to make exceptions for physician extenders.

Thank you very much for kind letter and I hope that my comments are

of some benefit to you.

Respectively,

FLOYD A. JONES, D.O., Diplomat, A.B.F.P.

[Western Union Mailgram]

RENO, NEV., March 22, 1977.

Senator DICK CLARK, (Attention David Harf). Washington, D.C.

DEAR SENATOR CLARK: We strongly urge your favorable consideration of S-708 and the suggested revisions as submitted by the Mountain State Health Corporation. We constantly experience the difficulty of attracting and holding physicians and we unanimously support establishing the position of a geriatric nurse practitioner in skilled nursing facilities.

CHARLES R. FEIST.

Administrator, Riverside Convalescent Hospital.

NENA COMPREHENSIVE HEALTH CENTER. New York, April 1, 1977.

Re S. 708 Leahy rural clinics reimbursement.

Hon. DICK CLARK,

Chairperson, Rural Development Subcommittee of the Senate Agriculture, Nutrition and Forestry Committee, U.S. Senate, Washington, D.C.

DEAR SENATORS: We the undersigned urge you to support the changes in the S708 bill which have been advised by the American Nurses Association.

The wording of this bill will have far reaching implications; interpretation of other health legislation, the viability of the nurse practitioner as a physician extender, and even the preservation of nursing as a profession may depend on

Nurse practitioners as well as physician assistants wish to be identified

clearly and separately.

In the spirit of professionalism (and reality) the term "supervision by a physician" must be altered to "consultation, collaboration or referral with the/

The best health care is provided when nurses and physicians work together in a collegial relationship. The term "Consultation Collaboration and referral" clearly provides for this vital, viable relationship between physicians and nurses in the delivery of health care.

Very truly yours,

PATRICIA MONDINI, F.N.P.-C.

CURTIS MEDICAL CENTER, Curtis, Nebr., March 24, 1977.

Re S. 708.

DICK CLARK.

Chairman, Patrick Leahy, Scnate Rural Development Subcommittee, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. CLARK AND MR. LEAHY: I hope that this letter reaches you before the March 29th hearing on the subject of Medicare reimbursement of rural health clinic services. I only received your request for imput on this matter

yesterday, March 23rd, at my rural Nebraska office.

I have a very strong personal interest in the area of Medicare reimbursement for physician extender services. I would not be practicing in this rural community of 1,100, 40 miles from any other medical facilities if it wasn't for the Physician Assistant who works with me here. I was originally sent to Curtis in July of 1972 as part of a National Health Service Corp team of two physicians. July in 1974 I decided to remain in Curtis after my term with the National Health Service Corp was finished. That year, there were about 140 physicians assigned to help manpower shortage areas and, of those, three of us decided to remain where we were. However, I stayed only because I knew that within one year I would be able to hire a Physician Assistant. The

practice was not large enough to support two physicians, even if another could be found (the National Health Service Corp wouldn't even send another phy-

sician).

Several months after hiring a Physician Assistant, I became aware of the fact that Medicare could not legally reimburse a physician for services rendered by a Physician Assistant unless the physician was personally present at the time services were rendered. This was quite disturbing for several reasons. Other third parties had been, and continue to, reimburse for those services with no questions asked. Blue Cross/Blue Shield representatives had been in our office, and had seen how services were provided and were reimbursing us. Life Insurance companies were paying for exams done primarily by the Physician Assistant, given final approval by myself, etc. I couldn't see how I could continue to function here and remain within the Social Security law. My Physician Assistant was alternating night call with me. He was seeing Medicare patients after hours, and if a simple problem was encountered I often would not be required to see the patient myself. We have a 50 bed nursing home in our community and he saw the patients there on an alternating basis with myself. If I had to personally supervise all the care given to Medicare patients, there wouldn't be much point in me hiring a Physician Assistant. On the other hand, I couldn't remain in practice in this community with those type of demands on my time.

August 1975, when I first became aware of this problem, I was reassured by a half a dozen Congressmen that legislation was pending to change the law. I, therefore, continued to do as I had before, and that was to allow my Physician Assistant to provide services as necessary and as accepted under his certification with the Nebraska State Board of Medical Examiners. I reviewed his work, sometimes the day after it was done, as I audited the medical records, and our office filed for all the services he provided under my

name.

August of 1976, carriers in our state for Mutual of Omaha began notifying patients and asking them who was seeing them and providing their medical care. I was contacted by personal letter and told that our practice here was in violation of the law and that it would have to cease. Once again, there were multiple communications with various Congressmen and the Department of Health, Education, and Welfare. Once again, I was told there was pending legislation and I also learned of the USC study. I became a participant in that project as of December 1976. All this time, my Physician Assistant has continued to see Medicare patients and our office has continued to bill Medicare for these services under my name. It is either doing that, or my leaving Curtis. I am very thankful that you have introduced this present legislation, as the sooner the air is cleared the better. I have lived with this problem for a year and a half too long already. The medical care in our area has not suffered, but I realize that it is not on a strictly legal basis.

I feel that reimbursement should be made for services provided, straight to the physician responsible for the care provided by the physician extender. I feel that our office provides a single standard medical care. If my Physician Assistant sees a simple problem, then he provides the same level of care and the same treatment that I would. This is determined by preestablished protocols. If on the other hand, he encounters a problem beyond his own competence, I am consulted and we go on from there. If I am not immediately available in the community (if I am gone for the weekend), there are other physicians in the area who will either advise the Physician Assistant on the

phone, or if necesary, see the patient themselves.

Since we do provide what we feel is a uniform standard of medical care, our charges are uniform. Everyone is charged the same, whether they see the P.A., myself, or both of us together. The patients seem to accept this as satisfactory in their minds too. Therefore I believe that Medicare should reimburse us for services rendered by the Physician Assistant at the same rate they would for those provided by the physician himself. This is accepted by private patients and I don't see why it should be any different for Medicare patients. A lower fee for services provided by Physician Assistants implies a lower level of care. We simply don't feel that that exists here, not as long as I or some other physician are available 24 hours to back up and assist the Physician Assistant.

If reimbursement is to be made available for physician extender services, then I believe that the physician supervising the care provided should in some

way show how that care is being supervised. This is fairly automatic in our state. I am sending you a copy, which in a sense, outlines the duties to be performed by my Physician Assistant in my practice. This type of thing is done on a practice-by-practice individual basis in the state of Nebraska, and is approved separately for each practice by the Board of Medical Examiners. I feel that as long as the physician and the Physician Assistant are providing care as a team and as approved by our state Board of Medical Examiners, this should provide the basis for an adequate reimbursement in order to receive Medicare reimbursement.

There is a question as to what type of certification process should be used for providers of these medical services. This should be uniform for all states but once again I feel that in our particular case, we are certified by our own state, and that should be adequate enough to be certified automatically by the Social Security Administration. Other states may not have the type of certification we have here in Nebraska, so perhaps something similar to what we have

here would have to established in those cases.

I hope that I have provided you with at least some useful information with this letter. I am looking forward to rapid approval and passage of the legislation in question.

Sincerely,

RONALD LAPP, M.D.

CURTIS MEDICAL CENTER, Curtis, Nebr., August 4, 1976.

Re Reimbursement to physicians for services of Physician Assistants for medicare patients.

THEODORE COOPER, M.D.,
Assistant Secretary for Health,

Department of Health, Education, and Welfare,

Washington, D.C.

DEAR DR. COOPER: I am writing to you about a problem that is gaining major significance in the area of rural health care delivery. It is also affecting me personally in my private medical practice. I hired a Physician's Assistant a little over a year ago, and was soon made aware of the fact that there was no current provision under the Social Security Act to provide reimbursement to physicians for the services provided by Physician's Assistants. I wrote to half a dozen congressmen last August urging their support in the passage of H.R. 7218 and S. 1897. These were bills designed to amend the Social Security Act in order to provide reimbursement to physicians for services provided to Medicare patients by Physician's Assistants, under their supervision. In the meantime, I have gone ahead and submitted claim forms to Medicare for services that were provided by the Physician's Assistant in my office, believing that the type of supervision I was providing was direct enough to fulfill the requirements of "direct supervision", and that appropriate legislation would be passed soon anyway. As it turned out, no legislation has been passed, and there is now a new bill being proposed by Congressman Symington, that is apparently superseding those previously mentioned. It is my understanding that the soonest any action can be expected on this type of legislation will be after the first of the year.

Enclosed, you will find a copy of some communication I have received from Mutual of Omaha, reminding me that Medicare does not authorize coverage of services provided by Physician's Assistants. The wording in these communications is vague, and can be interpreted rather broadly. Someone taking a rather narrow view of the medical practice situation, as it exists in my office, could demand a Medicare audit of the medical records and refuse payment for services provided to Medicare patients. A broader interpretation will allow what we are currently doing to continue on until the specific legislation is passed to clear the air. One gross error in the announcement, is that there is no provision for care provided by Physician's Assistant as an independent practitioner. I don't know of any Physician Assistant who operates as an independent

ent practitioner, at least in this state.

I would like to outline my personal situation here in Curtis, Nebraska. I have been in family practice a total of four years now. I was originally sent here as a member of a National Health Service Corps team and worked two years as a commissioned officer in the Public Health Service. I enjoyed the practice here enough to decide to stay in private practice. I was one of three physicians who decided to stay in a family practice setting of 160 physicians originally placed by the National Health Service Corp. In other words, this is one of the few successes the National Health Service Corps have had placing a physician

in a health care shortage area.

My decision to stay here in private practice was influenced to a great deal by whether or not I could obtain some help. The practice is not large enough for two physicians, but is too much for one person to handle 24 hours a day, every day of the year. I am the only physician in Frontier County with a population of about 3,000. Curtis has a population of 1,100 and is the site of the University of Nebraska School of Technical Agriculture. We also have a 50 bed nursing home. The nearest hospital is 40 miles. For the past year I have maintained a solely out-patient practice. I have informal agreements with several physicians primarily out of North Platte, Nebraska, for hospitalization of patients when necessary.

The first year I was in practice I participated in the Physician Assistant training program through the University of Nebraska and provided a training site for two P.A. students. A fairly large class graduated in May of 1975, and I hired a P.A. This P.A.s employment by our office, and my supervision of him, is fully approved through the State Licensing Board. We have established

lished protocols for the management of specific illnesses and conditions.

The Physician's Assistant, Mr. Lynn Caton, often sees a patient, and if their illness and associated treament fits in one of these protocols, he may institute therapy after making the appropriate diagnosis. If a situation does not fit within a protocol, he automatically consults me, or, if I am not immediately present or available, he is to consult with one of the several physicians in North Platte for their advice and possible referral, if necesary, of the patient to them directly.

If an elderly patient is ill at one o'clock in the morning at the nursing home, and Mr. Caton is taking call for the night, he might make an evaluation, consult me over the phone if necessary, and then institute therapy. Sometimes I am consulted and other times I am not. It all depends on whether the situation fits within his competence as determined by his training and by licensure requirements. I do review and countersign all contacts as they are recorded on

the medical record by Mr. Caton.

When I sign a Medicare claim form, I sign under a statement that states, the services were personally rendered by me, or it has been under my direct supervision. According to the State Law of Nebraska, my supervision is adequate as outlined above and I feel excellent medical care. Medicare takes a different view, apparently feeling that this statement means that the physician sees the patient personally, or at least looks over the shoulder of the Physician's Assistant. If this interpretation is enforced, then there is no point in my having a Physician's Assistant. If I can't hire a Physician's Assistant, I really won't be able to stay in Curtis. This then means that nursing home patients will have no direct supervision, as no physician is going to come 40 miles to Curtis to see them. It also means that acutely ill Medicare patients will have to go all the way to one of four other communities, all 40 miles away, to receive primary medical care.

Other third parties providing payment to this office for services seem to approve of the way the Physician's Assistant services are provided. Blue Cross/ Blue Shield is aware of his presence here. I have asked their representatives, pointedly, about coverage, and they state that as long as he is practicing under my supervision as provided by our State Law, that they will make payments to our office here. The Physician's Assistant here performs many life insurance physical examinations. He usually does the examination and then I check any questionable portions of the exam before I countersign. I have contacted several life insurance companies, some of which designate at the bottom of the for that "I, the physician, have personally examined this patient and have determined the above findings, and no other person has been involved". On telling these companies that the Physician Assistant makes the examination, they state that that is fine, as long as we both sign and I check any questionable findings. Mr. Caton also does examinations for Medicaid patients and provides medical services under my supervision. His signature is never on the claim form, but is on other forms we submit for the patients. (screening physical

examinations, etc.) I always countersign these forms, of course. Medicaid has

never hestitated to make payments for these services.

I would suspect that eventually the Social Security Act will be amended to allow for payment for Physician Assistant services. At the present time, I am stuck at a point where I have received the enclosed letter from Mutual of Omaha with no immediate legislation possible. It seems that Medicare could come up with some form of interim policy that would at least take the heat off until legislation is passed. I talked to W. F. Taylor, the sender of the letter, and he stated he was following orders as given to him from above. He is going to enforce the rules the best he can as interpreted in the letter. In his words, "There is going to be a crack down". We desperately need legislation to clean the air here, but more immediately we need some type of executive action to at least buy a little time. I would appreciate any support you can give to this matter, and any suggestions you might have for other appropriate, responsible persons who might be contacted.

I am also enclosing appropriate pages from the 1975 State of Nebraska Ap-

proved Duties of Physician's Assistants and Supervising Physicians.1

Thank you very much for giving this your attention.

Sincerely,

RONALD LAPP, M.D.

Siouxland Medical Education Foundation, Sioux City, Iowa, March 21, 1977.

Hon DICK CLARK, U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: Thank you for your invitation to testify on the Senate

Rural Development Sub Committee.

The whole rural medical care problem is dear to my heart. I feel that medicine should not be regionalized in Sioux City, Fort Dodge, Des Moines, etc. as has been proposed by some of our bureaucratic planners. I agree with most of your proposals and votes, but if you look into the early history of the physician assistants use in the state of Iowa you will find that financially aggressive physicians abused the use of the physician extender. It was only through a strong state medical society action that these abuses were curbed.

Physician Assistants and nurse practitioners have my whole hearted support. I have a nurse practioner working in my office at the present time. She is extremely capable and does a commendable job and is well like by patients. However, she is not capable of practicing medicine in isolated rural communities without medical guidance. I believe that to ask her to do this would be unfair to her and to the people who looked upon her as a capable, fully trained practitioner of medicine. I trust your Bill S708 would not allow isolation in

a rural community.

and the physicians.

The ideal situation for utilization of a Physicians Assistant in a rural setting exists at the present time in Kingsley, Iowa. Dr. Robert Powell and Dr. Charles Hamm have a Physician Assistant, Mr. Don Sumntzer, practicing under their direction. With the direction provided by Drs. Powell and Hamm, Mr. Sumntzer extends the quantity of medical services these physicians can provide without compromising medical proficiency. The Physicians Assistant in this situation is a valuable asset and provides a worthwhile service to the community, patients,

It is unfortunate that medicare and medicaids have refused to re-imburse Physician Assistant fees on the same basis as physicians. Under the circumstance at Kingsley, the services provided I am sure are essentially no different than if they were performed exclusivly by one of the physicians. The distinction made by Medicare/Medicaide is on the basis of who performs the service rather than the quality of care provided. Using that basis there could be a reimbursement criteria established with different rates depending on the religion or ethnic origin of the physician. That is facitious of course, but as long as the type or quality of service is not the basis for determining the level of re-imbursement, any one basis is an good (or bad) as another. Perhaps the

¹ Retained in files.

greatest problem in medicine today is the physician distribution inequity. Physicians tend to cluster in the East, West or the Southern resort areas where they receive three and four times the fees from third party insurance carriers, as compared to fee schedules in predominatly rural midwestern areas. For example, a \$200 fee in Iowa may be re-imbursed by Medicare at \$600-\$800 in the preferred areas. This variation is obviously not justifiable by differences in the cost of living between Sioux City and any other community. Hence, the compounding of cultural, continuing education, and financial disadvantages not only drives the physician from the underserved areas of the midwest, but also prevents recruiting significant numbers to relieve the shortage.

I suggest, and respectfully request you take a direct and forceful stand in favor of a schedule of fees for Medicare and Medicaid, and that the schedule of fees be based on a relative value scale. For example, the California Relative Value Scale which is already used extensively. Medicare and Medicaid reimbursement amounts would then be determined by applying to the relative value scale, a cost of living factor which would provide realistic variations between

geographic areas.

Physicians should be able to determine their own fee schedules, but at the same time reimbursement schedules would also be available to the public. I believe that once a fee schedule for Medicare/Medicaid reimbursement has been established that is fair, comprehensive, and easy to apply, that most physicians

will bring their schedules in line voluntarily.

This relative value scale approach would equalize physician income and discourage excessive fees. It would provide less incentive for physicians to migrate to the preferred geographic areas. Bureau of Labor and Statistics cost of living indexes, and that it would be understood by the public and physicians.

Your kindest regards,

MEL RITTGER,
Business Administrator.

Hot Springs Health Program, Hot Springs, N.C., March 22, 1977.

Senator DICK CLARK, Washington, D.C.

DEAR SENATOR CLARK: It has come to my attention that you are sponsoring the Senate Bill S-708. As President of the Hot Springs Health Program I wish to convey to you the sentiments and experience of my Board of Directors and the people of Madison County served by the Health Program.

Thirteen percent of the people of our country are 65 years of age or older. 2015 persons are legible for Medicare and medical services it provides re-

imbursement for.

There are four full time doctors in our county. Three are in private practice and do not provide the service of filling out Medicare forms, so in effect, do not serve the Medicare population. The remaining doctor is employed by the Hot Springs Health Program which does serve the Medicare population.

This physician's services are increased and inhanced by three family nurse practitioners, each providing primary medical care in a different clinic. The program's service area includes 35% of the population of the entire county and, if funding is received, will in May of this year expand to serve 56% of the

county.

Obviously there is no way our program's single physician can serve the entire Medicare population. Presently he rotates throughout the three clinics and attempts to see the Medicare patients that have appointments. This practice fails to provide adequately for all Medicare patients, especially those who need care

on the days the doctor is not available.

We are very proud of the model the Hot Springs Health Program has evolved. Our county is rural and situated in Appalachia, geographically and culturally. We have great difficulty here attracting doctors because of our isolation as well as our poverty. We are the fourth poorest county in North Carolina. But we still get sick and we still want our children to have a healthy life. We share the same needs and desires as people in larger and more prosperous communities.

Our solution has been physician extenders, which until now have been family nurse practitioners. Our nurses have provided medical care on a 24 hour basis

for the past five years to the people in four of our eight townships. They have struggled to overcome a bias toward physician preference and through their competence and constant availability have gained the confidence and deep appreciation of our people — especially those who would not otherwise receive medical care.

At present the Hot Springs Health Program is fighting for its life. The five year Appalachian Regional Commission funding ceases on April 30, 1977. It is our hope that a grant from the Rural Health Initiative will help us toward our goal of self-sufficiency in three years. We are fighting against terriffic odds. The median family income here is \$4,650 a year. One out of every five persons is at poverty level, 40% of all our people are less than 125% of the poverty level. We are trying to recruit a second physician, with great difficulty, but the bulk of our Medicare services will always be delivered by our physician extenders.

It is a puzzle to us why the same government that has helped to fund the education of our nurse practitioners, that thereby encouraged us to believe they were competent to deliver primary health care, refuses to reimburse their services unless they are acting under the supervision of a physician in his presence. What does this say to our older people when they come to our clinics for care on a non-doctor day and are told that if the nurse practitioner sees them, the same one who saw them before they turned 65, they can expect neither Medicare payments nor an accrual of the amount they must personally pay before receiving Medicare's medical benefits? It says these practitioners are second rate, their attention is not worth paying for. It says this so loudly that many receiving Medicare do not utilize our health program. They are too proud to owe and unable to travel elsewhere. These individuals end up receiving no medical care. Their plight also effects the rest of the community — their sons and daughters, their grandchildren — who are subtly influenced to think that the nurse practitioner does not give top rate professional health care.

What I have just described has great influence on the future of the Hot Springs Health Program. If it fails financially 56% of the county will lose local medical services, a transportation program for the sick and a home health

program. That would be a disaster.

Is the federal government really interested in bringing health care to rural areas? Or is the Appalachian Regional Commission and Rural Health Initiative funding really only stop gap attempts to make us believe that we are the objects of the government's concern. We don't need health care for three or five years, we need it available everyday for a lifetime. The only way this can happen is to go for long term solutions — ours has been the nurse practitioners.

I, and the members of the Hot Springs Health Program, hereby endorse the bill you are sponsoring and request that this letter be entered in written

Sincerely yours,

THOMAS WALLIN,
President, Hot Springs Health Program.

ORTING, WASH., April 1, 1977.

Hon. RICHARD G. CLARK. Old Senate Office Bldg., Washington, D.C.

Dear Senator Clark: We as a community are very interested in S-708, now being considered by the Rural Health Subcommittee. We would like the word "Supervisor" replaced by the phrase "physical consultation which is reimbursable."

We have not been able to keep a doctor in our community of Orting. Many residents do not have transportation to other communities.

We are now served by a nurse practitioner. She, backed by several doctors who practice in neighboring towns, can provide care to patients entering the health care system and continue in that care. Being able to provide many services that the doctor himself approves of, she has been the answer to a great need in our town.

Senate Bill 708, if so changed, will allow us to continue to enjoy the services

of our nurse practitioner.

Sincerely,

ESTHER SMITH. Member Orting Health Council.

MELLETTE COUNTY RURAL AMBULATORY CARE CLINIC, White River, S. Dak., March 25, 1977.

Hon. RICHARD CLARK,

Senate Rural Development Subcommittee, U.S. Senate, Washington, D.C.

Dear Senator Clark: I am in support of Senate Bill 708.

I am a nurse practitioner in White River, South Dakota. Approximately 10% of our patients are Medicare eligible. I have been dismayed at having to tell them that they cannot see me since Medicare will not reimburse them except on the day that my sponsoring physician, Dr. Robert H. Hayes, is here. You can imagine the confusion.

Our state laws cover physician extender activities rather well. Certifiction in our state is contingent upon certification nationally. My impression is that state

laws should be adequate.

Federal programs can audit our work since they are the payers. P.S.R.O. can then audit our work for quality of care. We are proud of it and are willing to be examined by them.

I urge the committee to press for passage of Senate Bill 708.

Sincerely.

PAUL FRANCOIS, R.N., F.N.P., White River, S. Dak.

WHITE RIVER, S. DAK., March 25, 1977.

Re S. Bill 708.

DAVID HARF,

Office of Senator Dick Clark,

Washington, D.C.

DEAR Mr. CLARK: I would like to inform you of my support and many of the people of this rural community's of Senate Bill 708.

I personally have seen the effects of Medicare payments in our community. White River is a small (660 pop.) town and the closest hospital or doctor is 55 miles away. We have had the services of a fine Physician Extender for a little over a year now and feel extremely fortunate to have him. I am a mother of 4 children, have a degree in Medical Technonlogy, and serve as a EMT for our volunteer ambulance service. I work part time at the clinic and have seen the effect of that the payment of Medicare has made on the health care of our elderly patients. Many have neither the income nor the transportation to get to a doctor when necessary. I'm sure that it is safe to say that lives have been saved because they are now able to come here to get needed medical care.

Our clinic was approved for Medicare payments last November. I strongly

urge you to support Senate Bill 708 so that other communities can benefit from

this service.

Thank you very much.

BARBARA JONES,

St. Mary's Hospital (Convent), Richmond, Va.

Hon. DICK CLARK, Washington, D.C.

DEAR SENATOR CLARK: I am a nurse practitioner (family) in a rural area of Henrico County, Virginia.

I am in support of Senate Bill 708 which would amend title XVIII of the Social Security Act to reimburse the health services provided by nurse practitioners and other P.A. and MEDEX in rural areas.

I work full time in this rural area, with a low income people, am unable to get any kind of reimbursement for the care given, to help support the project because our clinic is nurse run and does not have a physician on site.

Sincerely,

SISTER ELAINE DAVIA, R.N., F.N.P.

[Western Union Telegram]

BROOKLYN, N.Y., March 31, 1977.

Senator DICK CLARK, Capitol One, D.C.:

Delete Physician Extendor, substitute Nurse Practitioner, replace phrase Physician Supervision with Physician Consultation, Bill S. 708.

Ms Helen Lauricella, Family Nurse Practitioner, Coney Island Hospital.

COTULLA, Tex., March 25, 1977.

Senator Dick Clark, Chairman, Senate Rural Development Subcommittee, U.S. Senate, Washington, D.C.

Dear Senator Clark: For the past seven years I have been working in very rural areas of South Texas. I have experienced the great needs of the Migrant farmworkers, the seasonalworkers, the rural poor. Obtaining health services for these people is often times a real struggle or even impossible. Historically, the rural population has experienced critical health manpower shortage and has consequently been victimized by a dearth of primary care services.

Health care should be the right of all individuals and not merely of a selected few who can economically afford such care, travel to urban areas or are

lucky enough to recruit a physician to a rural area.

One of the ways that I feel would definitely help the situation in Rural Areas would be by passage of S. 708, your bill to permit medicare reimbursement to rural health clinics.

I am wholeheartedly in favor of such a bill. I do however wish to raise some of my concerns and comments and would hope that they will be seriously taken as they have great effect on whether or not the bill would truly help to

eliminate the discrimination shown in the past to rural areas.

As a registered nurse and a pediatric nurse practitioner and presently working with a rural group having *great* difficulties in obtaining federal funding for an *extremely* needed area in South Texas I view the following statement as vitally important.

The bill states that it uses the term "physicians extenders to signify the types of primary health providers that work in rural health clinic." This statement is fine, however, the bill then goes on and actually discriminates in the following statement: "The bill would define 'physician extender' as one who is certified as an adult - family nurse practitioner by the American Nursing Association or as a physician's assistant by the National Commission on Certification of Physician's Assistants." By this statement you are considering only two classes or groups of physician extenders in this area and none would qualify for third party re-imbursement under this bill. All are working in Migrant, Neighborhood or Rural Health Centers. By stipulating "adult-family nurse practitioner" you have excluded pediatric nurse practitioners, obstetrical nurse practitioners, geriatric nurse practitioners and nurse midwives. Why? By requiring certification by the American Nursing Association you discriminate against those certified by the American Academy of Nurse Midwives, National Association of Pediatric Nurse Practitioners/Associates etc. Why?

I trust that the above mentioned concern was an oversight and can be

remedied so as to making re-imbursement to physician extenders.

I do want to thank you for your concern and interest in the needs of Rural America. Those of us trying to meet these medical needs are extremely grate-

If there is any way we can provide more supportive assistance in securing proper legislation please feel free to call or write me.

Respectfully yours,

SISTER PAULINE BOYER, R.N.-P.N.A.

University of South Dakota, School of Medicine, RURAL AMBULATORY CARE CLINIC, Wall, S. Dak., March 23, 1977.

Hon. RICHARD CLARK, U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: Upon reading Senate bill 708, I would like to make the following comments. This bill interested me greatly since I am a physician extender in a rural area (a certified Family Nurse Practitioner and Physician

Assistant by National Certification.)

Our clinic started operation December 8, 1975. Dr. Robert H. Hayes, the physician, is at the clinic approximately three days per week. At the present time, we are reimbursed by Medicare for services performed only on the days that Dr. Hayes is in the clinic. This is discriminatory to our patients who are sick on other days because our closest M.D. is 36 miles away.

The patients have been very pleased with the services at our clinic. If reimbursement for the physician extender is made at a smaller rate than the physician, this would indicate that the treatment received is inferior.

We would welcome P.S.R.O. to review our records. This would serve to prove that the care given by our clinic is excellent.

Thank you for allowing me to express my opinion at this time.

Sincerely.

BARBARA PIERCE, R.N., F.N.P., P.A.

MARCH 28, 1977.

Hon. DICK CLARK. Senate Rural Development Subcommittee, Washington, D.C.

DEAR SENATOR CLARK: Thank you for the opportunity to submit written testimony for the Subcommittee Hearing on S. 708.

We strongly support S. 708 and the concept of providing Medicare reimbursement to support Rural Health Clinics and Communities that lack full time physicians by using physicians extenders. There are literally hundreds of small communities in the State of Missouri that do not have primary care and treatment. In fact there are some entire counties in the state that are without primary health care of any kind.

There is little, if any prospect, that these small communities and counties can recruit and retain full time licensed physicians. At the same time, a substantial amount of primary health care can be provided by physician extenders working under the supervision of a licensed physician, and being re-

imbursed by third party payors.

Actually, this College has conducted a de facto physician extender program for nearly thirty years. Senior student physicians, under the supervision of licensed physicians, staff nine Rural Extension Clinics in small towns, without resident physicians within a 50 mile radius of Kirksville. These Clinics provide primary health care which would not otherwise be available.

Again, we strongly support S. 708 and deeply appreciate the opportunity

of giving testimony in favor of it.

Cordially.

J. S. Denslow, D.O.

[Western Union Mailgram]

LINCOLN, NEBR., March 24, 1977.

DAVID HARF. Office of Senator Dick Clark, Washington, D.C.:

Since I received the request for comment on the Rural Health Clinic bill on the day before the reply was to be in your office. My reply could only be filed this method.

I would certainly support this bill in that one of the overriding reasons for a physician to employ a physician's assistant is to make more efficient use of the physician's time. One of the great wastes of physicians' time in rural communities is the travel time between nursing homes. Sending a physician's assistant to assess these chronically ill patients and reviewing their current needs greatly extends his efficiency. In Nebraska P.A. are licensed to a specific position and are responsible through him for the care of the patients. All State licenses do not have this close tie with the physician who is then ultimately responsible for the care of the patient. I would think that there must be a direct line of responsibility to a designated physician who then has the medical liability in the case. This will certainly tend to weed out the poor physician's assistants because no physician will take this risk without thoroughly trusting the clinical judgment of the physician's assistant.

Reimbursement should then be at the same level as if the physician were present and doing the work because he would be assuming the same respon-

sibilities as though he were there personally.

Sincerely,

DALE W. EBERS, M.D. Lincoln Pediatric Group.

[Western Union Mailgram]

Lyndonville, Vt., March 28, 1977.

DAVID HARF, Office of Senator Clark, Washington, D.C.:

I urge passage of S. 708. This is a start for recognition of value of R.N.'s in health care. Do not omit pediatrics, etc., when addressing bill to nurse practitioners specialities. Do not call R.N.'s that degrading name "physicianextender"; lawyers are not called judge-extenders.

Thanks,

FALLS CITY, NEBR., March 23, 1977.

DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR MR. CLARK: This letter concerns the subject of Medicare reimburse-

ment of rural health clinic services-more specifically bill S. 708.

I am a rural Doctor of Medicine practicing in the small Nebraska town of Falls City. I have been here about fifteen years. My partner left because of low income and excessive work in 1969 and I practiced solo since that time through my inclination was to change practice sites for the basic reason that is impossible seemingly to recruit family physicians to a small rural community.

I have found long hours and relatively low compensation to be major factors in this problem as we are in a poor competitive position as regards our fee scales, availability of facilities and consultants and an apparent discrimination on fee scales by third party carriers such as Blue Cross, Welfare and

Medicare in comparison to urban practices.

In July 1977 I acquired the services of a Physicians Assistant to help ease the work load and give me a little more free time. Obviously the current Medicare policy hampers my ability to utilize his help.

A few points to illustrate the problem:

1. We have a high percentage.

1. We have three nursing homes in the town. We have a high percentage of elderly, retired people in our population and these homes have a high occupancy rate. These people are seldom seen on a regular basis. This is an injustice and better preventive care could be implemented if the P.A. could see them on a fairly regular basis and report back to me his current findings.

2. Hospital regulations require a complete physical which could be performed by the P.A. and the physician could concentrate on the acute complaint—this eliminating considerable time consuming, nonproductive labor.

3. If I am not in the office at a particular time we have to refuse seeing medicare patients at that time, schedule them at a later date, or call me in from some other activity. It would seem that the P.A. should be allowed to cover these times and report back to me when I'm readily available to discuss findings and treatment.

Obviously there are other areas involving Medicare patients where P.A.s could be utilized in routine care and I'm anxious and concerned about the current status of things. Rural medicine is on a steady downhill course and

the full utilization of paramedics has to be part of the solution.

I feel reimbursement has to be at the physician's usual pay scale for his services. As mentioned before we are already at a disadvantage. My P.A. is payed a salary, and percentage of his gross business which just about breaks even with his costs and my office overhead and allows nothing for the time I spend consulting and advising regarding his findings and treatment.

We certainly hope this situation can be remedied and clarified. Personally if something is not done, or if we should lose any additional physicians in

our area I would have to again consider leaving rural practice.

Sincerely,

BILL G. FARMER, M.D.

ISSAQUAH, WASH., March 25, 1977.

Hon. DICK CLARK,

Senate Office Building, Washington, D.C.

DEAR SENATOR CLARK: Please replace the wording in the S. 708 Rural Clinics Reimbursement Bill from "supervisor" with "physician Consultation which is reimbursable"

This will better enable the nurse practitioner in rural clinics to provide health care needed as a licensed health professional. The nurse practitioner is licensed to practice nursing and legally liable for her/his own practice.

Sincerely,

SHIRLEY M. GILFORD, R.N., School Nurse, Seattle School District.

SEATTLE, WASH., March 24, 1977.

Senator DICK CLARK,

Senate Office Bldg., Washington, D.C.

DEAR SENATOR CLARK: As a member of the Nurse Practice Committee of the United States Public Health Hospital of Seattle, Washington, I am writing to you in support of S. 708, the Rural Clinics Reimbursement Bill.

There is a great need at this time to change the word "supervisor" with the

phrase "physician consultant which is reimbursable."

Nurses compose the greatest number of health care providers in the United States. There are 1 million registered nurses and only 380,000 doctors. In the rural health care facilities nurses are the "backbone" of these clinics and should be reimbursed accordingly.

We the undersigned urge you to make these word changes.

Sincerely yours,

ESTHER BROLIN BAILEY, R.N.

MARSHALLTOWN.

Senator Clark: I feel that the elderly would be better served by the proposed legislation Bill S. 708.

Medicare must reimburse the elderly person for services received at rural health care clinics. These services can be well provided by the nurse practitioner and A.N.A. certified nurse.

Direct or indirect supervision of a physician is absolutely not necessary! Nurses have been providing nursing care without the presence of a physician!

They can and they do make referrals to physicians when needed.

I suggest that nursing referrals to: a physician-podiatrist and various health care disciplines including psychologist and social services be reimbursed by medicare as well.

Sincerely,

M. HALA.

[Western Union Telegram]

NEW YORK, N.Y., March 29, 1977.

Senator DICK CLARK, Capitol One, D.C.:

S. 708, please delete physician extender, substitute nurse practitioner. Replace phrase physician supervision with physician consultation.

MARY HERBERMANN.

[Western Union Telegram]

FORT LEE, N.J., March 28, 1977.

Senator DICK CLARK, Capitol One, D.C .:

Bill S. 708, please urge committee to replace physician supervision with physician consultation which is reimbursable.

JANET NATAPOFF EDD, R.N.

ST. ANTHONYS CONVENT, Brooklyn, N.Y., March 19, 1977.

Hon. Senator DICK CLARK, 404 Russell Bldg., Washington, D.C.

DEAR SENATOR CLARK: As a former missionary and teacher as a Sister of St. Joseph, now retired and working for N.Y. State Dept. of Mental Hygiene I

know the needs of rural peoples.

Doctors are not always available neither are midwives therefore we need legislation to bring the needed care to people where people are in need. This means we need legislation to provide nurses and paramedics with a license to qualify them to give the needed injection, prenatal care, primary care and treatment to citizens and non-citizens (to people) who generally lack other sources of basic health care. One cannot always find strong enough poles or men to carry the patient in a sheet over rural mountains and roads for miles

to a nearby hospital. Ambulances do not go everywhere.

Today we live in an era of preventive health care, crises teams, to prevent breakdowns. This is where rural health clinics are most important. The extender-staffed clinics tend to emphasize preventive health care, educate patients about proper NUTRITION and other self-help techniques in order to prevent the necessary care by a physician or hospital personnel; maintaining good health is a necessity everywhere.

Rural health clinics become the primary step in health care and should have a back up physician and hospital to refer patients. In dollars and cents they

cost less to both individual, family, community and country.

Please include individuals who need the care of a Mental Health Team.

Sincerely,

Sister Francis Gerard Kress, CSJ,
Member of Network and the National Assembly of Women Religious.

NELIGH, NEBR., March 24, 1977.

DAVID HARF,

Office of Senator Dick Clark,

Washington, D.C.

DEAR MR. HARF: I have employed Physician's Assistants for a couple of years and have found them to be of great service in providing health care in this rural area.

Physician's Assistants work according to the laws in the State of Nebraska pertaining to the utilization of Physician's Assistants which does not require

"over the shoulder" supervision.

I feel that Medicare should be required to pay the usual physician's fees for treatment rendered by Physician's Assistants according to law in the particular locality.

Sincerely,

KENNETH PIERSON, M.D.

[Western Union Telegram]

MASON CITY, IOWA, March 29, 1977.

DICK CLARK, Chairman, Senate Rural Development Subcommittee, Capitol One, D.C.:

Strongly support S-708 for S.S.A. reimbursement to make physician extenders accessible to patients in greatest need. Recommend through clinic group to avoid encouragement to independent practice. Physician group fully responsible for all activities of extenders. Type of certification responsibility of various States.

Dr. Norman W. Hoover. Dr. John K. MacGregor.

CORALVILLE, IOWA, March 22, 1977.

DEAR SENATOR CLARK: In answer to your request for comments on Bill S-708, there are just a few points I would like to emphasize. In the first place, you must keep in mind the difference between necessary availability, and convenient availability of physicians. If a physician is within a 20-30 minute ride, he can be considered to be available to many patients—not just those within a 10 or 15 minute ride. Even in large cities, where there are many physicians from which to choose, it may take a patient 30 minutes to get to an office.

Again, it seems imperative to recognize that somehow, all the efforts in the field of health care delivery should dovetail. This state legislature places no importance on its health department—they are poorly funded, and understaffed. Yet they are the ones to set standards and through which grants must flow, for new ambulances or driver training for them. As I keep saying, let's make certain that patients in rural, or isolated areas, can be taken to a hospital, rather than constantly trying to get the care out to the patient exclusively! There are funds from the Highway Safety Act—but we have a

hard time qualifying for them-lack of "state studies" and other impediments. There once was a plan to coordinate communication equipment in ambulance across the state so that a patient could be rushed across several counties, if necessary to be brought to a center suited to his particular needs. None of this gets done. The public feels let down. Federal and State programs must complement.

Next point is that all para-medics or physician-extenders must be securely fastened to a physician, at all times, or you are into a morass of legal en-

tanglements, and also opening the door to all the jelly beans who profess to be "helping people" or curing them.

The last issue is a large item unto itself—before you add any more recipients or providers to the Health Care Systems—let's go over the statistics thoroughly—and get the persons, or companies who are making huge profits at the expense of those least able to defend themselves—primarily the elderly. A check of hospitals, or of bill collection agencies, or of computer programs, such as the one here in this state which makes a great deal of money just keeping health statistics!

You are certainly on the right track in emphasizing health care needs in this state—but until the public is motivated to implement a cohesive program they will sit out here and each small community will continue spending its

money, competing with its neighbors, instead of working with them!

Yours Very Sincerely,

Mrs. MICHAEL BANFIGLIO.

P.S. Meanwhile, back at the Ranch, The Federal Manpower Act required an increased enrollment to provide more doctors for small towns. This our Medical School has done. The Federal support for the program has now been decreased, and the state has been picking up slack in the past 3 years.

This year however, the state of Iowa's legislators have decided with the help of our Gov. to cut back on this aid to medical schools, and we have a shortage of funding in the medical school. This is likely to result in the curtailment of medical school programs! So while the Right hand Giveth-the Left hand taketh away! Please try to encourage more federal funding of those programs and grants formerly awarded to medical colleges! Please try to influence our Legislators to keep up the funding for our Medical Schools. Unless somebody makes a big noise—we are back to square one!

KEYSTONE, IOWA, March 17, 1977.

Senator DICK CLARK. U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: Thank you for sending me your comments and the bill S. 708. I feel you do understand and I appreciate your honest effort for

the needed changes.

With modern means of transportation and laboratory services, I feel more doctors can be enticed to move into the rural areas if — The fee schedule is the same as the urban doctor. It is a myth that the overhead is less in a small town. The nurses, office assistants, x-ray technicians demand the same pay as the urban ones or they drive to the city to work. Also the supply of good help is less and the repair services of specialized office equipment higher. Either the equipment has to be transported into the city or the repair man paid to come out to the office - for example, repairs on the x-ray machine. The small grocery store, etc. charge more than the larger stores in the city and frequently one has to drive to the city for correct merchandise. The savings of the property tax is quickly offset by the above reasons.

Still it is a great place to live and the people in the rural areas deserve

to have the same quality of physician care as the urban citizens.

Sincerely,

WILLIAM H. STEINBECK, M.D.

Dear Senator Clark: I received your mailings concerning the rural health bill and heartily concur with what you are trying to do to help provide the rural people with better health care coverage. I speak from interest on this bill in two areas. First I am Vice-Chairman of Subarea V of the Iowa Health Systems Agency. I meet and talk with these people from the rural areas all the time and I am sure that this bill will help to provide medical services, which are not now covered under Medicare. Secondly, we have one Family Practice resident from the University of Iowa rotating through our offices each month to teach them obstetrics and also gynecology. We are encouraging the young men and women to settle in rural areas so that the problems of the rural population can be better served.

Very truly yours,

Drs. McGee, Kent, Burlington, Iowa.

COLUMBIA, S.C., March 16, 1977.

Mr. DAVID HARF,

Office of Senator Dick Clark, Chairman, Rural Development Subcommittee, U.S. Senate, Washington, D.C.

Dear Mr. Harf: The physician shortage in South Carolina is very acute; the maldistribution of physicians make the shortage critical in rural areas of our state. To offset this shortage and to add a needed dimension to the quality of health care, nurse practitioners are used in some health department clinics. More could be utilized if the Social Security Act could be amended to allow payment for rural health clinic services in general, and nurse practitioner services in those clinics more specifically. The existing medicare regulation that prohibits reimbursement to clinics that lack fulltime physicians is a major obstacle to providing care to citizens in rural areas. It is precisely because of the shortage of and maldistribution of physicians that creates the need to utilize physicans assistants and/or nurse practitioners to extend care to people in the more isolated areas. Nurse practitioners operate in South Carolina with full legal sanction and with physician preceptor back-up and with specific written, medical protocols individualized to her demonstrated competence areas, so the safety of her care is unquestionable.

Reimbursement can be either on a fee-for-service basis as for physicians, or can be made to the organized system in which she works, such as the health

department or private clinic.

Clinics should, of course, have a systematized arrangement for physician back-up and referral in order to qualify for reimbursement.

Where national certification exists, it should be made a requirement for the

nurse practitioner to be reimbursed.

We appreciate the efforts you are making in this matter.

Sincerely,

DORIS W. LISTER, R.N.

WARMINSTER, PA., March 21, 1977.

DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR Mr. HARF: S.B. 708 is excellent. The concerns expressed by Senator Clark are indeed real. This type of legislation would help facilitate health care distribution in an efficient and effective manner in rural clinics.

Reimbursements for services provided should go to the health care facility and not to the individual care provider. When I speak of provider I mean physician, nurse practitioner or physicians assistant. I would certainly hope that the term "Physician extender" would not be used N.P.'s and P.A.'s should

be defined separately in this same bill.

This bill states that a N.P. works "under the general supervision of a physician." Senator Clark mentions this in regard to medical aspects and not nursing aspects of the practice. This I would see as time for defining what medical protocols would be used to regulate the practice, and also collaboration in regard to patients. I value the collaborative relationship between N.P. and physician even if it is only for a short time every week. I also value my own nursing activities that promote health usage within my practice. The combination is a good one.

I would hope that this distinction would be elaborated upon within the future language of this bill.

It is with best personal regards that I encourage you in this excellent bill. Sincerely,

(Mrs.) SANDRA CRANDALL, R.N., C., M.S.N., F.N.S.

LONG BEACH, CALIF., March 23, 1977.

Senator DICK CLARK. Chairman, Senate Rural Development Subcommittee, U.S. Senate, Washington, D.C.

DEAR SENATOR CLARK: I would like to commend you and your committee on the work you have done in the introduction of S. 708, to amend title XVIII of the Social Security Act. This important measure, to provide payment for rural health clinic services rendered by nurse practitioners' and physician assistants' is, as you are well aware, a vital step in increasing the availability and accessibility of health care services to those who live in rural areas. Many nurse practitioners' such as myself, would be attracted to

rural areas if there was reimbursement for our services.

In the bill, nurse practitioners' were included in the definition of "physician extenders." I feel this term implies that nurse practitioners' are only extending "physician" services when in essence they are providing a broad range of services including health maintenance and preventative care. Therefore, the use of the term "physician extender" would be misleading to the consumer of health ears services as it does not constitute its latest the services. consumer of health care services, as it does not correctly identify the nurse practitioner. The nurse practitioner is a distinct category of health care provider who works in collaboration with physicians for which provision is made. This could be done through electronic means when a physician in not physically present for collaboration and consultation. In place of "physician extender" the generic terms such as nurse practitioner and physician assistant would be used. If this is not possible, the term "non-physician" provider could be substituted.

Again I would like to say that I am pleased with the work that has been

done and urge you to continue your efforts.

Sincerely.

FRANCES M. DEVLIN, R.N., Family Nurse Practitioner.

DANBURY, IOWA, March 24, 1977.

DAVID HARF, Office of Senator Clark, Washington, D.C.

DEAR SIR: In regard to the hearing on bill S. 708, permitting Medicare re-

imbursement to rural health clinics for primary services.

As I understand at the present time these services are not being reimbursed by Medicare, therefore persons needing this care either must pay for it themselves, go without or depend on someone else to pay for it. For this reason I support this bill which I feel would provide more complete care in these rural areas where there is a severe lack of physicians.

The reimbursements could be made directly to the clinic providing the services and in return this clinic would be responsible for supervision from the physicians of the Nurse Practitioners and Physician's Assistants services, re-

ferrals, management policies, insurance, etc.

The certification of such persons could be done by already established Boards. With a minimum standard set on a national bases and if it felt necessary to place more regulation on a local base this could be done.

Sincerely.

GLORIA WELTE.

STATEMENT OF LAURA G. LARSON, R.N., BOISE, IDAHO

DEAR SENATORS CLARK AND LEAHY: I appreciate the opportunity to submit this statement in behalf of S. 708 at the hearing on March 29, 1977.

As a recent retiree, I represent no particular group or organization. Notice of this hearing prompted me to speak out as a concerned taxpayer and in the interest of millions of older citizens who, like me, may require primary and preventive health services and nursing home care in the future.

During my years of service (nursing and administration, 1957-1967) with the Idaho Department of Health in the licensure and Medicare certification of hospitals and nursing homes, I observed or recommended the closure of small hospitals in rural communities as physicians migrated to the urban

centers for more cultural and professional advantages.

The registered nurses who had staffed these closed hospitals remained in the community, captive by virtue of husbands and families. It soon became apparent that patients and families were seeking out these nurses for advice in health problems, in emergencies and for follow-up treatment upon returning from adjacent hospitals. The physicians, now practicing in the urban center, soon learned to rely on the "eyes and ears" of these captive nurses.

Observations of patients' vital signs, symptoms and complaints were re-

layed to the physician, who in turn outlined the medical treatment carried out by the nurse. These telephone communications became the order of the

day and ushered in a new concept of "long distance" health care.

While this was professionally rewarding to the nurse, the financial rewards

It has been said that necessity is the mother of invention, and so an idea was born. Why not assist registered nurses to gain additional skills in physical assessment and treatment of minor illnesses, return them to their community and provide medical backup from physicians in the adjacent medical

centers, - indeed, why not?

The successful family nurse practitioner program launched by the Mountain States Regional Medical Program in 1969 is now a matter of record. To date, about 140 registered nurses have, with financial assistance through HEW and other funds, completed short-term courses (4 mo. to 1 year) at University Medical Centers. They have become proficient in physical assessment, treatment of minor illnesses and accidents, and are now certified as family, pediatric or geriatric nurse practitioners. With physician back-up, they are functioning in a variety of settings: physicians' offices, public health clinics, rural community clinics and nursing homes. They are providing a vital service, relied upon by Medicare and Medicaid patients.

Payment, however, for these nurse practitioner services is becoming an increasing problem. Provision must be made for these essential services and

passage of S. 708 becomes more urgent and critical with each passing day.

In this connection, however, I would like to propose a modification of S.
708. I propose that wherever the term "rural health clinic (or services)"

appears in the bill, the term or skilled nursing facility be inserted.

The almost total absence of the physician in nursing homes has been well documented and referred to as "the shunned responsibility." Physicians are really not interested in the routine day-to-day health problems of elderly patients. Nor is it physically possible or financially feasible to provide daily physician visits. Neither are patient health care needs being adequately met by the present regulatory visits at 30-60-90 day intervals.

A qualified nurse practitioner is the most logical person to fill the gaps in health services caused by the physicians absence from the nursing home. However, provision must be made through S. 708 to make reimbursement for

such services.

The majority of elderly patients are admitted to nursing homes after the acute phase of their illness has been stabilized. No longer requiring acute hospital care, but still unable to function independently, these elderly patients continue to be subject to considerable discomfort from their chronic health problems and disabilities. The "ups and downs" of their chronic condition

does not always require monitoring by a physician.

It has been documented that utilizing nurse practitioners in nursing homes provides more frequent contact, making a vital contribution to the health and morale of the infirm, poor, and elderly. They can evaluate or re-evaluate the patient's status, institute prompt measures to alleviate minor problems, thus prevent further complications. The highly skilled physician should be utilized only when major medical intervention is required. In fact, the very term skilled nursing facility connotes the services provided are predominantly nursing, not medical.

As the number of patients over 65 years of age continues to increase, all community resources and the skills of all health professionals must be fully utilized in order to keep the health services viable and within a manageable

S. 708 will provide the reimbursement mechanism for payment of such

"physician extender" services.

I strongly urge your favorable consideration of this bill and the suggested modification in this testimony.

Thank you for this opportunity to comment.

THE ANNISTON STAR. Anniston, Ala., March 23, 1977.

To the members of the Senate Rural Development Subcommittee, as a newspaper reporter whose training is not in the field of health care, I am unable to offer any testimony from a technical standpoint. However, my work has brought me close to people in a three-county area of east Alabama, and a

general discussion of health care in the region may be of some use.

The three counties — Cleburne, Clay and Randolph — are isolated, hemmed in by the southernmost foothills of the Appalachians. As a result they have a common ethnic and cultural heritage, with the best and worst aspects of "hill country" life preserved longer than it has been in neighboring counties which developed urban centers by actively attracting industry. The largest town in this tri-county region is Roanoke, in Randolph County, with 5,000 people. Cleburne County has four incorporated towns, none with a population over 2,900; Clay has two incorporated towns.

At one time these counties were, by the standards of rural Alabama, moderately prosperous. But as cotton farming became less lucrative over the course of this century, and factory jobs in neighboring counties drew wouldbe tenants from the land, prosperity declined. All three counties have lost population steadily since 1900. Much of what was farmland, especially in Cleburne County, has been sold to large paper companies and reforested. The only way this forest acreage contributes to Cleburne is through nominal annual land taxes, an amount much smaller that what the county gained when the land was in farm production.

The decline in population has meant a decline in services—particularly health services. Cleburne County has three doctors for 10,000 people; Clay and Randolph are comparable, though not quite as underserved. But a doctor-

patient ratio doesn't tell the whole story.

All of the doctors in this region live in the largest towns, and rural residents who live in the "wrong end" of their counties must drive between 10 and 30 miles to reach them. The three Cleburne County doctors, for instance, live in Heflin, the county seat. Heflin is near the center of the county, about 15 miles from Cleburne's northern border and 20 from Ranburne, a town in the south with about 500 people. When one of Heflin's doctors became involved in a political controversy recently, residents throughout the county tried to pressure the newspaper into downplaying the story, because they were worried the doctor would leave Cleburne County.

Physician-extender clinics appear to be an answer to the health care problem, at least in east Alabama. A clinic began operating in the Randolph County community of Woodland last month and at least one other is scheduled to open soon. Donna Dale, the nurse-practitioner in Woodland, reports no major problems after six weeks at work and says the people of Woodland are very receptive.

The people of Woodland, and most of the tri-county area, are also very poor. And a large percentage are elderly, or anyway a percentage larger than the statewide figure. Any assistance a rural health clinic can receive through Medicare payments would benefit these people by making their health care more accessible and immediate.

If I can be of further assistance, please contact me.

Respectfully submitted.

THOMAS NOLAND.

WINTERSET, IOWA, March 18, 1977.

Hon. DICK CLARK,

U.S. Senator, Washington, D.C.

DEAR SENATOR: By way of introduction, I would like to say that I have been an elected County officer for twelve years, serving on County, Multi County and on the State Health Systems Agency the needs of our population in health care.

A number of our elderly are being discriminated against because there are no Doctors in their towns and they are required to travel miles to the nearest Doctor and generally they have no transportation or there is but a single

Doctor that is so over worked that it takes days to get to see him.

I know for a fact that many Physician's assistants, work in a Doctors office, see patients, take blood pressure, blood samples, shots for various ailments, use of the stethoscope and many other things that are recorded on ones medical chart, where you are required to see the Doctor periodically. and the patient, having never seen the Doctor and yet he pays for a Doctors office call, and yet Medicare and other supplemental insurance's, if any pay for the call.

What would be the difference in a Clinic? This would enable the elderly to have much better Medical attention. I don't believe that a Nurse practitioner or a Physician's assistant in a clinic, if no Doctor was present, should be allowed to charge more than 60% of what a Doctor would charge for an

office call.

There should be some standardization of the amount of education required

before either could work in a clinic.

This does not pertain to this bill, but certainly needs immediate attention of the Congress to help the elderly to help themselves and it is this, that Medicare should cover people in nursing homes and not just (Skilled Facilities) because there are less than 30 in the State of Iowa, and of course all

other insurance companies write the same.

There are literally thousands of elderly people, that don't understand insurance, that are buying these nursing home policies thinking they would be covered in any nursing home, but find that when they need it, it is only in a Skilled Facility. These people should be protected against this sort of thing, but better yet lower the standards of Medicare so they would be covered and the insurance companies would soon fall in line.

Gentleman of the Congress don't ever forget that todays retired are yes-

terdays tax payer.

ORVILLE C. WILLCOX.

STATEMENT OF PETER FISHER, SANTA BARBARA, CALIF.

Thank you for your kind invitation to submit testimony to your March 29, 1977, hearing on the subject to Medicare reimbursement of rural health clinic services.

I am sorry to state that I have no specific remedy to offer for the very real and tragic problem created by the denial of reimbursement by Medicare for health services provided by nurse practitioners and physician assistants in rural clinics not attended by licensed medical doctors.

As consultant to Congressman Lagomarsino on national health insurance, this particular problem caused me great concern in writing his National Voluntary Medical and Hospital Services Insurance Act, H.R. 957. Although I gave it much thought, I was unable to devise an acceptable and workable method of extending the medical service benefits of the Plan to cover services provided by nurses and physician assistants not under the direct supervision of medical doctors.

Like Medicare, our bill is intended to pay for all necessary and available medical services which, by definition, must be provided only by or under the direct supervision of a medical doctor. The problem now being faced by your subcommittee can only be solved either by changing the definition of "medical service" or by physically providing a licensed doctor in each rural clinic. Both of these solutions are outside of the scope and jurisdiction of Medicare, or of H.R. 957.

Section 36 of H.R. 957 defines the scope of the bill, which would replace Medicare as well as Medicaid, as follows: "The purpose of this Act is to provide only for the establishment of a national voluntary insurance Agency and Plan to pay all reasonable costs of all necessary and appropriate medical, pathological laboratory and hospital services, and such other additional benefits as may be added in the future, for all enrollees when and where such services are available from approved, participating and non-excluded providers; and the resources of the Agency and Plan shall not be used in any way directly to regulate the quality or availability of, or to establish or operate, such services; and if adequate services are not available when and where required by enrollees, the Agency shall have no responsibility or liability to provide such services; and in consideration of the aforestated limited scope and purpose of this Act, enrollment in and subscription to the Plan shall be voluntary for all enrollees and subscribers; and by so limiting the scope and purpose of this Act to the providing of economic access to presently available health services, any deficiencies in the quality, quantity, methods, economics and distribution of those services should be clearly revealed and may then be corrected or improved by the health care profession or appropriate public or private agencies outside of the separate of the National Voluntary Medical and Hospital Services Insurance Plan."

In short, H.R. 957 expresses my own view that any actual deficiencies within the health care delivery system itself cannot properly be solved by any national health insurance program, or Medicare or Medicaid, although such programs can and do help to illuminate and define the deficiencies

which can then be approached directly through other means.

I will look forward with great interest to the findings of your subcommittee in the hope that any solution you can find to this particular problem will be equally applicable under the National Voluntary Medical and Hospital Services Insurance Act when it is enacted by Congress.

NEW YORK, N.Y.

Hon. DICK CLARK, Russell Bldg., Washington, D.C.

DEAR SIR: Thank you for your letter in which you suggested that I submit to you my views on the pitfalls of Medicare program in regard of payments provided to nurse practitioners.

The following is my personal testimony and experience in the years between 1965-1974, when I provided my services for the rural hospitals of Sullivan

County in State of New York.

My name is Hana Hudeck, I am a member of American Association of Nurse Anesthetists. Mr. Chairman and members of the Subcommittee on June 7, 1974 I have personally testified before the Committee on Ways and Means, and had a meeting with (at that time) Chairman Wilburn D. Mills, on March 12, 1975 I have submitted written testimony to the same committee on the subject of freelance nurse anesthetists, it's exploitation and unfair labor practice.

Mr. Chairman, as you well know by our previous testimony and being well acquainted with the Medicare provisions of payments, the nurse anesthetists has been completely excluded from any direct payments not only from Medicare, but also from Medicaid and other private insurance companies. At the time I have worked in Sullivan County, New York, myself and my colleagues

had to work under the following conditions.

HAMILTON AVENUE HOSPITAL, MONTICELLO, N.Y.

The surgeon Doctor C.K. Heins paid the nurse anesthetists himself for anesthesia services administered to his patients. When we administered anesthesia for any other Doctor at the above hospital, we had to collect the payment ourself the best way we could, many times not being paid at all. When I terminated my services at the above hospital. I was advised by Doctor Hems, (co-owner of Hamilton Avenue Hospital with Doctor Vytautas Slavinskas, also the administrator) to press charges at small claim court for the services I have administered to other surgeons and Doctor Slavinskas re-

fuse to pay, even though he asked me to give the anesthesia. This is what happened. When the local Judge J. Levine contacted Doctor Slavinska, Doctor Slavinska composed a masterpiece of a letter which I am enclosing for you to see how easy it is for the hospital administrator to get out of paying for the services rendered.

GENERAL COMMUNITY HOSPITAL IN LIBERTY AND MONTICELLO

These Hospitals paid the nurse anesthetists for Medicaid and Welfare cases only as the local Department of Welfare refused to have anything to do with the re-imbursement to nurse anesthetists. As a matter of fact Mr. Chairman on the only one occasion I was able to have meeting with the Commissioner of Welfare Mr. Robert Travis to discuss the matter of re-imbursement, in the middle of my sentence Mr. Travis got up, walked out of his office and never returned. This is the kind of public representative one has to deal with. By now as you well can imagine Mr. Chairman the conditions with the re-imbursement were so improper, that most of the nurse anesthetists left the County or were replaced by M.D. anesthetists, some with little formal training, none Board Certified.

Another situation that I would like to bring to your attention is the widespread fraud. As I have given to you few examples of how difficult it is for the nurse anesthetists to collect the re-imbursements for her services, she or he often turns to M.D. anesthetist for help in regard of re-imbursement. The Doctor will collect for the nurse anesthetist signing the Medicare forms himself on the fee splitting bases, splitting it in such a way that most of the cut

went into his own pocket.

Therefore Mr. Chairman and the Members of the Subcommittee I strongly urge you to consider in making an Amendment of the Medicare Law in favor of direct re-imbursement to the party who provides the service, be it nurse anesthetist or M.D. anesthetist, in the rural areas where they work independently. I also would like to point out that only board certified members should be re-imbursed for their services so to limit the unqualified and unskilled people to administer the anesthesia in regard to patients safety.

Mr. Chairman and the members of the Subcommittee I thank you for giving me this time and opportunity to bring these typical cases to your attention.

Respectfully yours,

HANA HUDECEK, CRNA.

INTERNAL MEDICINE, P.C., Sioux City, Iowa, March 21, 1977.

Senator Dick CLARK, U.S. Senate Washington, D.C. (Attention of David Harf.)

DEAR SENATOR CLARK: I have reviewed with interest the material that you

DEAR SENATOR CLARK: I have reviewed with interest the material that you sent me summarizing your hearings on rural health.

It is essential that physician extenders work directly under the supervision and direction of a physician. The office or clinic in which he works could conceivably be connected with the physicians office by closed circuit television. The physician, therefore, would be able to observe the patient and render meaningful consultation concerning his further care. This would not be as valuable in the examination of the patient as the actual "laying on of hands," but it would enable the physician to render a judgment on whether or not but it would enable the physician to render a judgment on whether or not further examination was necessary.

One of the main fears of the patients living in areas where a physician is not available is that they do not have any opportunity for help and the presence of a physician extender in the community would be reassuring to

The physician extenders, of course, should be remunerated for their services. They, however, do not have the in depth training of physicians and should not be allowed to practice without the close supervision and association with a physician. Wide spread abuse of the Health Security Act could result if such an arrangement is not a very specific requirement.

Sincerely yours,

GEORGE G. SPELLMAN, M.D.

SEELEY LAKE, MONT., March 22, 1977.

Gentlemen: As senior citizens in our 70's, we are receiving Medicare—and hope that the skilled nursing care that we get from our local Health Center enabling us to remain in our home will be covered by Medicare.

As we understand it, Senate Bill 708 will allow us to be covered by Medicare

for the services we are now getting.

Please give it your favorable attention.

Sincerely,

JAMES T. AND BERTHA M. SULLIVAN.

MARCH 22, 1977.

Mr. DAVID HARF. Office of Senator Dick Clark, Washington, D.C.

DEAR MR. HARF: I am writing in reference to the Rural Health Clinic Bill. As a Registered Nurse in Community Health Nursing in a Southern State, I have personally seen and found very frustrating situations like those described in the text of this bill. Rural areas without available health services leave the residents with alternatives such as poorer quality of life and unnecessary deaths.

Legislation of this sort would assist the small communities in my own area by making it possible for primary health services where there have

been only limited (primarily screening) services.

I agree with the recommendations regarding the manner of reimbursement with Medicaid and Medicare. The seven criteria listed in order to qualify for Medicare reimbursement appeared to be all-inclusive and reasonable in their expectations.

Could the certification process include a daily checksheet/quarterly report

combination with routine audit as a supportive measure?

As a professional, I feel that it is imperative for this law to be changed in order that our community will be able to recruit and secure this type of medical service for our community.

Sincerely,

WYNNE NEELEY, Registered Nurse, Community Health Nurse.

CALLAWAY, NEBR., March 23, 1977.

SENATE RURAL DEVELOPMENT SUBCOMMITTEE, Russell Senate Office Bldg., Washington, D.C.

DEAR SIRS: I am a physican in rural Nebraska who employs a physicians assistant. It would be nearly impossible for me to adequately care for all of my patients without such assistance. My P.A. works as an extension of myself and consultation with me concerning patients is always available when necessary. Those of us who have P.A.'s know their capabilities and limitations. We also know how essential they are in allowing a single practitioner such as myself to continue practicing in rural areas.

It is my belief that new certification processes and billing procedures are totally unnecessary. They would only serve to increase health costs not quality

of health care.

Physicians assistants can and do give quality medical care to other than medicare patients under physician supervision both direct and indirect. Why should medicare patients be different? Their problems are the same.

My P.A. sees patients in the clinic and hospital on a routine and emergency basis. His practice of medicine as an extension of myself is approved by the State of Nebraska and covered by my liability insurance. There is no difference in billing. If he sees a patient, they are billed through the clinic as if I had seen them. To do any differently, means the patient is getting a different quality of care than if they were seen by me. We do not believe that such is the case. The differential in patient care comes in the selection of which one of us sees the person based on the complexity of their problem. There are obviously complicated medical and surgical problems that necessitate the attention of a physician. Hopefully there remains enough faith in the medical profession to allow us to make these decisions rather than a board far removed from the situation.

In effect, we are delivering good health care in rural areas at a reasonable cost. Instead of complicating the process, I would suggest that more regulation, certification and billing procedures would only serve to increase health care

costs, not health care quality.

Sincerely,

R. J. SHEPPARD, M.D.

STATEMENT OF KIM CARNEY, Ph. D., UNIVERSITY OF TEXAS AT ARLINGTON

As an economist concerned with the maldistribution of health resources in this country, I support passage of S. 708, or similar legislation, that would enable rural health clinics to receive reimbursement under Medicare for health services provided by nurse practitioners and physicians assistants. Similar changes in Medicaid are also desirable.

There are three general reasons for support of such legislation. (1) The legislation will enable a number of existing, badly needed rural health clinics to continue in operation. (2) The legislation will encourage the formation of new clinics. (3) It will also demonstrate that financing measures for health services need not lock us unto a delivery system prevailing at the time that the financ-

ing legislation was written.

It is, of course, the case that there are numerous rural health clinics presently in existence in which physician extenders are providing badly needed care in circumstances in which no physician is present. Some of the clinics were established under various short term or start-up grants and will be forced to close down if they cannot become self-supporting. For the most part, these clinics are functioning in a highly desirable emphasizing preventative and ambulatory care. Many clinics are also concerned with environmental health. Such clinics are generally very cost effective.

However, the existing health clinics are small in number in respect to the need for such clinics. There are numerous areas in the United States where population density is so low that the area will never be able to support a full time physician. In the absence of third-party reimbursement for extender services at the present time there has been little incentive to establish needed clinics. The development of additional clinics would be greatly stimulated by

modification of reimbursement arrangements.

There are many regions in Texas too sparsely populated to support a physician. More than half of the 254 counties in Texas are predominantly rural and 94 counties have a population density of ten or less per square mile. There is no physician in 22 counties, and many of the 17 physicians in counties with a single doctor are close to retirement age. Although physician extender training programs are relatively new, there is growing evidence that extenders set-

tling in rural areas tend to remain in those areas.

Too often financing mechanisms, whether public or private, have been difficult to modify and have functioned as an obstacle to improvement of the health delivery system. For example, the tendency of financing plans to cover hospitalization but not ambulatory care has functioned as a disincentive for the seeking of early care, possibly care that would prevent later more serious illness. Such disincentives not only discourage the seeking of needed health care but contribute to rising prices and expenditures for health services. The proposed legislation not only encourages the continuation and development of health resources in scarcity areas, but it also indicates that financing mechanisms are subject to modification and are not necessarily a force supporting the status quo.

Medicare (and Medicaid and private insurance) should cover services provided by physician extenders, in the absence of a physician, when such services are provided in an organized, non-profit clinic where the extenders are salaried,

rather than paid on a fee-for-service basis.

Toledo, Iowa, March 22, 1977.

Re S. 708. DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

DEAR SENATOR CLARK: The use of nurse practitioners and physicians assistants here in Tama County would be very advantageous because of the scarcity of doctors and the many small communities. There are 6 towns with-

out doctors.

Reimbursement should be to the doctor responsible for the supervision of the nurse practitioners and physician assistants, but such reimbursement should not penalize the doctor if he also treats the patient. You see, at the present time, it is the policy of Title XIX to reimburse the doctor for only one treatment per month. If such a patient develops an illness, more than one treatment is frequently required. Most doctors will see the patient as many times as necessary, even though they know they will be paid for only one Call. If a Title XIX patient is seen by a physician extender and is subsequently seen by the doctor, both charges should be paid by HEW.

Some doctors, knowing more than one Call per month will be necessary, will place the patient in the hospital where all charges are paid 100%.

Also, out here in rural Iowa, most of the medical care is done outside of the hospital. To encourage doctors to locate in small cities and to assist the development of satellite clinics, the "usual and customary" fee should be paid for the care of Title XIX patients. At the present time, the regular charge for a Title XIX patient is sent in by the doctor. The powers that be then pay the doctor only a fraction of that amount. The amount is a certain percentage over the doctor's charges that he made in 1970. However, in the hospital X was and Laboratory absence a residual of the contraction of the same and the contraction of the contraction of the made in 1970. pital, X-ray and Laboratory charges are paid 100%.

Sincerely yours,

C. W. MAPLETHORPE, JR., M.D.

Morrisville, Vt., March 22, 1977.

DEAR SIRS: On such short notice, it is exceedingly difficult to prepare a lengthy testimony, but I would like the following, and the enclosed pertinent information included in the testimony in the Tuesday Mar. 29 hearing.

First of all, I am opposed to any further federal interference into matters of health, rural or otherwise. I feel that government funds and concern, too soon lead to government controls. We have the examples of Great Britain and Sweden, to name two who have socialized medicine. We can see how impersonal, and unprofessional their medical practice has become. They wait to be seen by the doctor of the government's choice, in a clinic, having to wait hours many times. When they finally see the doctors, they are often unhelped or too sick for help. We do not need any further Socialistic modes of medicine or in any other area. America is fast slipping into the hands of Socialism, with the help of legislation like the Rural Health Clinic Bill. Please, as our Senators, do something in favor of the freedom of the American people, rather than dragging us further into bondage. A Statesman is truly a person with the purpose of furthering the cause of our Constitutional Republic, please I hope there are some left. Don't be responsible for selling our Republic into another Communicated as a state.

selling our Republic into another Communist slave state.

Secondly, I would simply state that I feel the reason of dwindling country doctors is the increase in overbearing federal regulations which are ridicu-

lous, impossible to meet with, and downright unconstitutional.

Thank you.

MISS DELORES LABARGE.

MARCH 19, 1977.

Hon. DICK CLARK. U.S. Senate. Washington, D.C.

DEAR SENATOR CLARK: Thank you for sending the materials on rural health care in Iowa. I found them very interesting and also read S. 708 with interest.

You are correct that there are many small Iowa communities that do not have and probably never will have a resident physician. Frequently this is due to the trend of physicians to develop group practices and regional health care facilities. The group environment and regional cost base is essential to providing a high level of medical expertise. The expectations of the public, for the most part, have changed over the past 20 years and nearly everyone wants today the best possible health care.

If Medicare regulations are changed to permit reimbursement for physician extender services not rendered under direct physician supervision, two cate-

gories of service should be designated.

The first would be physician assistants practicing as satellites to a sponsoring physician. Perhaps criteria for participation in this designation should include a specific distance from a regular physician's office in addition to being an underserved area. Also, remote locations should be subject to PSRO protocol to qualify for Medicare participation.

The second category is the physician assistant practicing in the same facility as his physician employer. This category probably has the most to offer in extending physician services. They are presently inhibited by Medicare regulations which require direct supervision. Your proposed legislation would impact

in a very positive fashion on this category.

Reimoursement for physician extenders services should be made to the sponsoring physician based upon his established Medicare fee profile. Participation should not mandate acceptance of assignment until Medicare allowances substantially exceed the current 70 to 80% rate. The amount of business done and charges generated by a physician extender probably will not substantially exceed his salary and overhead in most cases. However, this aspect should be monitored as a condition of participation in the program.

Just a couple of other thoughts in closing—the satellite office could be used as a tool by one hospital group to penetrate another hospital trade area. Also, the term "clinic" usually implies a multi-specialty group practice. Perhaps the clinic term should not be used in legislation pertaining to physician assistants.

Sincerely yours,

CHET HELLAND.

GRAND ISLE, Vt., March 21, 1977.

Mr. DAVID HARF, Office of Senator Dick Clark, Washington, D.C.

Dear Sir: In reply to your letter of March 7, 1977, advising me of the hearing to be held on March 29th. on S. 708, a bill to permit Medicare reimbursement to rural health clinics. I am sure there is very little information I can add to the oral testimony which will be given. However for your information the Champlain Islands Health Center, in Grand Isle, Vermont, provides primary care to approximately three hundred patients a month. During the less than three years we have been caring for these patients, we have seen over one hundred eighty different patients, many of them on a weekly basis, who are covered by Medicare. These patients are on a no-fee basis which causes a considerable loss to our income. If there was a provision for us to be reimbursed for these patients it certainly would help our financial situation.

Sincerely,

Frances R. Vantine, Accounts Receivable Clerk.

RENTON, WASH., March 24, 1977.

Hon. Dick Clark, Old Senate Office Bldg., Washington, D.C.

DEAR SENATOR CLARK: I am writing to you in response from a bulletin from Margaret Ouchi, Director of Government Relations for The Washington State Nurses Association. My concerns I wish to express to you concern S. 708 Rural Clinics Reimbursement.

I request that you replace the word "supervisor" with the phrase "physician

consultation which is reimbursable."

I support the testimony you have heard from the American Nurses Association concerning this bill. I am a Pediatric Nurse Practitioner and am in private practice with two pediatricians. I have patients scheduled to see me at which

time I do an intake health history, perform a complete physical examination and based on my findings make a diagnosis. Those patients scheduled as my appointments are seem for child health maintenance. I, also, see patients who are ill at which time I take a health history, perform a physical examination and make a diagnosis based on my findings prior to collaboration with the physician. I, also, initiate treatment based on my diagnosis.

I am a registered nurse who has completed a post-R.N. nursing education program designed to provide me with the expertise to function as a pediatric nurse practitioner. I am licensed by the State of Washington, I am legally liable

for my own practice and I carry personal malpractice insurance.

I hope this information will be of help to you as you begin hearings in the U.S. Senate Rural Health Subcommittee.

Very truly yours,

DELORIS JOAN WOODS, R.N., Pediatric Nurse Practitioner.

[Western Union Telegram]

SEATTLE, WASH., March 25, 1977.

Senator Dick Clark, Rural Development Subcommittee, Washington, D.C.:

S. 708 Rural Clinics Reimbursement replace the word supervisor with phrase "physician consultation which is reimbursable".

SHIRLEY MIDDLETON.

[Western Union Telegram]

ROCHESTER, N.Y., March 27, 1977.

Senator DICK CLARK, U.S. Senate, Washington, D.C.:

Urge support for health care by nurses with physician consultation not supervision S708 Leahy Bill.

SUSAN ROBERTS, R.N.

[Western Union Telegram]

PLEASANTVILLE, N.Y., March 28, 1977.

Senator Dick Clark, Capitol One, D.C.:

Urge S. 708 be changed from Physician Supervision to Physician Consultation and Referral.

MADELINE LARAIA.

Arapahoe Clinic, Arapahoe, Nebr., March 29, 1977.

DAVID HARF, Office of Senator Clark, Russell Bldg., Washington, D.C.

Dear Mr. Harf: Thank you for the opportunity of commenting on the rural health clinic bill. I don't envy your task of trying to sort out these problems during a one day hearing. Having been in general practice since 1959, and presently the only MD in a town of 1200 population. I know this to be a more complex problem that can be covered in one day. My personal experience with the Physician's Assistant program here in Nebraska, not only through participating in their preceptor training program but also in having a graduate Physician's Assistant working with me for about a year and a half now, I feel I have had some experience in this area. The program as it has worked here in our office has been a good one. I feel that the graduates of our Nebraska program have received excellent training and are capable of performing a wide variety of functions in a physician's office as well as in the hospital setting.

This need not be under direct supervision at all times, however and that requirement somewhat defeats the purpose of the program in the first place. I feel strongly that the physician should be totally responsible for the actions of a PA or nurse practitioner and that the services rendered by the assistant should be of equal quality as if the physician had performed the service personally. If the assistant is not able to do this, then that duty should not be delegated to him, or the physician, in fact, should be in direct attendance at that time.

These are situations that of necessity must be worked out on an individual basis but as long as the physician is held responsible for all the actions of his assistant and as long as the service rendered is done in a proper and ethical manner, then I see no reason for the Physician's Assistant not to be reimbursed just as the physician would be, that is equal pay for equal service. I find this is a difficult concept for third party carriers to grasp hence the wide descrepancy in charges allowed for the same procedures done in Metropolitan as opposed to rural areas. I think this is an inequity that needs to be corrected and is one of the contributing factors to lack of physicians in rural areas, but that's another problem, isn't it!

I feel that it would not be appropriate or wise for Physician's Assistants or nurse practitioners to be allowed to function totally independent of a supervising physician. This would, in effect, create competition and would tend to defeat the purpose of the program eventually. I think it's imperative that everyone involved work together to solve the rural health problems as they

exist today.

I do not feel that it should be a necessary requirement that the physician be physically present when a Physician's Assistant renders a service, in that the concept of satellite clinics manned primarily by Physicians' Assistants should be accepted. The physician, however, should be in attendance part of the time and should be available by telephone all of the time and physically available to provide on the spot additional care within approximately thirty minutes in case some emergency situation should arise.

I think further there should be a limit as to the number of Physician's Assistants that could be supervised by one physician. As for example, two or possibly three in certain circumstances. That would be in areas where population is extremely sparce and no other more feasible arrangement would be

made. This concept would be limited to rural areas only.

I also feel that the majority of these decisions would have to be made on an individual basis, on a local, county or centainly state level. One set of rules would not cover all situations across the whole country. Each area has it's own unique problems. I have found through experience that when given the opportunity to do so, most rural areas are very capable of solving their own problems and we'll be much more likely to come up with a system that works well for them than if they are required to follow rules and regulations proposed by a distant bureaucrat. Guidelines of a general nature would be appropriate, however.

Insofar as certification, I think I have covered that. It should be on a state level. In other words, each state should be allowed to determine how many PA's one physician could employ and at what distance from his primary office any satellite clinic could be set up. It would be inappropriate to say that they all had to be within thirty miles, let's say, when in some areas much greater distances might be involved between isolated rural areas. The requirements of training, testing, etc. should be in the hands of State Medical Licensing Boards, as it is now for physicians, dentists, etc. General guidelines on a federal level would be appropriate to insure uniformity of ability from one state to another.

I noticed on my calendar that your hearing is taking place today and I'm sorry that this letter will not be received by you in time to be of any benefit, however. I have given some thought to what I have said and I have rewritten the letter a couple of times, and I apologize for not having this information to you in time. However, hopefully it will be of some value to you.

Sincerely,

[The following form letter was submitted and signed by 38 individuals.]

RICHMOND, VA., March 23, 1977.

Hon. DICK CLARK. 404 Russell Bldg., Washington, D.C.

DEAR SENATOR CLARK: I am a nurse practitioner in the Richmond metropolitan area. I am in support of Senate Bill 708 which would amend title XVIII of the Social Security Act to reimburse the health services provided by nurse practitioners, physician assistants, and MEDEX in rural areas. I believe the passage of such a bill will improve accessibility of health care in medically deprived areas.

Yours truly,

PATRICIA M. ROBERTS, R.N., Family Nurse Practitioner Student.

MARCH 20, 1977.

From: Malcolm E. Vail, resident and freeman of the town of Hubbardton, Rutland County, Republic of Vermont.

To: David Harf, Office of Senator Dick Clark, '04 Russell Bldg., Washington,

By: Senator Patrick Leahy.

Subject: Medicare reimbursement of Rural Health Clinic Services.

Reference: Senator Leahy's letter dated March 7, 1977.

As requested by Senator Leahy's letter which came only a few days ago, my comments on the adequacy of Medicare reimbursement of rural health care clinics is necessarily prepared without too much documentation, in the interest of getting something in to you, which might or might not be better than nothing, especially if what I say is wrong.

First Hubbardton, located about 7 miles from a small medical center in Rutland, 23 miles from a big hospital in Rutland, belonging to the Fair Haven Rescue Squadron, having our own Volunteer Fire Dept., having approved payment of \$500.00 annual dues to the Visiting Nurse Association, another \$100.00 for the Rutland Opportunity Council, Inc. belonging to the Rutland Regional Planning Commission, who administers the Area Office on Aging, with an Information and Referral Service, having a retired Dentist as our Town Health Officer, and consisting of about 220-240 people according to census estimates, might have 2 to 3 times that number when the summer crowd moves into their camps and cottages. We are a rural community consisting of three localities, Hubbardton stretched out along Vermont State Highway #30, Hortonia, a cross roads at the south end of a lake having the same name, and a place near the site of Vermont's only revolutionary military conflict.

My closest neighbor and friend, a senior citizen by most definitions suffered a heart attack and/or stroke last spring. Covered by Blue Cross insurance at the cost of slightly more than \$30.00 per billing period, his medical expenses have been compensated for at the regular rate of 80% of authorized health care. Everything from hospitalization expenses, X-Rays, doctor's fees, pills, transportation, consultants' fees as well as expenses at the Veteran's Hospital in White River Junction, Vermont seem to have been paid. One complaint that a \$25.00 service charge was not allowed due to delay in submitting necessary paper work was overshadowed by the overall total of expenses for which compensation was made however.

I believe there are much more than adequate provisions extant in the Rutland County area to take care of our health needs. We have the tooth fairy dental program for school children, a Town Service Officer appointed by the selectmen to serve as "on the spot" representatives of the Department of Social Welfare. The visiting nurse has bathed my neighbor, attended to therapy training, and performed other visits. According to last year's report the visiting nurse provided 240 skilled nursing visits, 25 physical therapy visits and 203 Home-maker Home health Aide Visits to Hubbardton people.

In December 1976, a presentation was given to the Rutland Regional Plan-

ning Commission concerning a Comprehensive Health Planning Program. Rep-

resentatives would be assigned from each county and from both "consumer" and "provider" groups to a Board of Directors, and would work with a Vermont State Health Coordinating Council, with the Vermont Health Planning and Development Agency, with HEW and any or all Health Care activities.

From the foregoing, and in my particular case where outpatient medical service at a military installation is not allowed since I am a retired military serviceman, living beyond the 40 mile radius limit for such care; and I and my dependents would be covered by the CHAMPS program, as are many others who are classified as military veterans, there is an awful lot of opportunities to help the sick and wounded, the aged, the young, the handicapped and most groups of people who have private organizations looking out for their interests. Being a contributor to the march of dimes, the community chest, or red feather, or United Fund, or the Disabled American Veterans (the last group I contributed money to) and seeing where a new self addressed envelope (not stamped though) is still to be stuffed with green and returned to the Vermont Achievement Center in Rutland, among other Health Agencies, I begin to wonder.

Two big things tend to disturb me. FIRST, is the federal government in competition with private, state, or local interests in trying to meet the health needs of Americans, and might not better service result at a dollar saving to all of us if the federal government stuck to seeing that our foods and drugs were safe to consume, that smoking is indeed injurious to our health and stop subsidizing tobacco growing, support new cures for killer diseases like cancer, epidemics, and tending to medical care for the armed forces and

government employees at Bethesda, Water Reed, et cetera.

Secondly, I got the feeling that anybody who gets sick or just doesn't feel good believes that he has a right to get free medical attention, medicines, drugs, nursing care, and/or compensation to whatever expenses he can pry out of the U.S. Treasury. One of the best buys on the market is a pair of eye glasses at Woolworth's in down town Rutland. All one has to do is keep trying on different pairs until the price tags on the items for sale can be read. The cost is less than \$5.00 and compares favorably to the \$51.00 at the eye doctor, who after reading the eye chart, one eye at a time, looking at lights through his fancy eye machine checker, ordering the prescription after picking out the frame style, then going through the fitting exercise, takes three weeks at the least.

The above observations are written in haste and are personal opinions, not

necessarily those who have or are using health services.

MALCOLM VAIL.

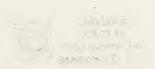
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